

## WISEWOMAN FOLLOW-UP RESCREEN (HOT PINK) FRONT



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
**WISEWOMAN Follow-Up Rescreen**  
 Completed at 4th Health Coaching Session



|           |            |                |                  |                            |
|-----------|------------|----------------|------------------|----------------------------|
| LAST NAME | FIRST NAME | MIDDLE INITIAL | DOB (MM/DD/YYYY) | DATE OF VISIT (MM/DD/YYYY) |
|-----------|------------|----------------|------------------|----------------------------|

**A. Health History (Check ☒ as appropriate)**

1. Do you have high cholesterol?  
*If you answered No, skip to question 2.*

a. Do you take medication to lower your cholesterol?  
 i. Is the medication a statin?

b. If yes, during the past seven (7) days, including today, how many days did you take prescribed medication to lower your cholesterol?

☐ Yes ☐ No ☐ Don't Know/Not Sure

☐ Yes ☐ No ☐ Don't Know/Not Sure

☐ Yes ☐ No ☐ Don't Know/Not Sure

\_\_\_\_\_ Number of Days

☐ None, I could not obtain medication

☐ Don't Know/Not Sure
2. Do you have hypertension (high blood pressure)?  
*If you answered No, skip to question 3.*

a. Do you take medication to lower your blood pressure?

b. If yes, during the past seven (7) days, how many days did you take prescribed medication (including diuretics/water pills) to lower your blood pressure?

c. Do you measure your blood pressure at home or use another blood pressure machine located in the community?  
*If no, check reason:*

*If yes:*

i. How often do you measure your blood pressure at home or use another blood pressure machine located in the community?

ii. Do you regularly share blood pressure readings with your health care provider for feedback?

☐ Yes ☐ No ☐ Don't Know/Not Sure

☐ Yes ☐ No ☐ Don't Know/Not Sure

\_\_\_\_\_ Number of Days

☐ None, I could not obtain medication

☐ Don't Know/Not Sure

☐ Yes ☐ No

☐ I was never told to measure my blood pressure

☐ I don't know how to measure my blood pressure

☐ I don't have equipment to measure my blood pressure

☐ Multiple times per day

☐ Daily ☐ A few times per week

☐ Weekly ☐ Monthly

☐ Other (don't measure)

☐ Don't Know/Not Sure

☐ Yes ☐ No ☐ Don't Know/Not Sure
3. Do you have diabetes (Either Type 1 or Type 2)?  
*If you answered No, skip to question 4.*

a. Do you take medication to lower your blood sugar (for diabetes)?

b. If yes, during the past seven (7) days, how many days did you take prescribed medication to lower blood sugar (for diabetes)?

☐ Yes ☐ No ☐ Don't Know/Not Sure

☐ Yes ☐ No ☐ Don't Know/Not Sure

\_\_\_\_\_ Number of days

☐ None, I could not obtain medication

☐ Don't Know/Not Sure
4. Have you been diagnosed by a healthcare provider as having any of these conditions:

a. Stroke/transient ischemic attack (TIA)

b. Heart attack

c. Coronary heart disease

d. Heart failure

e. Vascular disease (peripheral arterial disease)

f. Congenital heart defects?

☐ Yes ☐ No ☐ Don't Know/Not Sure

☐ Yes ☐ No ☐ Don't Know/Not Sure

☐ Yes ☐ No ☐ Don't Know/Not Sure

☐ Yes ☐ No ☐ Don't Know/Not Sure

☐ Yes ☐ No ☐ Don't Know/Not Sure

☐ Yes ☐ No ☐ Don't Know/Not Sure
5. Are you taking an aspirin daily to prevent heart attack or stroke?

☐ Yes ☐ No

MO 580-3320 (10-19)

DHSS-VWW-A-04 (10-19)

## WISEWOMAN FOLLOW-UP RESCREEN (HOT PINK) BACK

### B. Health History (Check ☒ as appropriate)

1. How many cups of fruit and vegetables do you eat in an average day? ☐ Cups ☐ None
2. Do you eat two (2) servings or more of fish weekly? ☐ Yes ☐ No
3. How many servings of grain products do you eat in a typical day? ☐ ½ serving or less ☐ ½ serving
4. How many servings are whole grains (oatmeal, cereal, bread, etc.)? ☐ ½ serving or more ☐ None
5. Do you drink less than 36 ounces (450 calories) of beverages with added sugars weekly? ☐ ½ serving or less ☐ ½ serving
6. Are you currently watching or reducing your sodium or salt intake? ☐ ½ serving or more ☐ None
7. Physical Activity ☐ Yes ☐ No
  - a. How many minutes of physical activity (exercise) do you get in a week? \_\_\_\_ Number of minutes ☐ None
8. Alcohol ☐ Yes ☐ No
  - a. In the past seven (7) days, how often did you have a drink containing alcohol? \_\_\_\_ Number of days ☐ Don't Known/Not Sure
  - b. How many alcoholic drinks, on average, do you consume during a day you drink? \_\_\_\_ Number of drinks containing alcohol
9. Overall Wellness  
Over the past two (2) weeks, how often have you been bothered by any of the following problems?
  - a. Have little interest or pleasure in doing things? ☐ Not at all ☐ Several days  
☐ More than half of the month  
☐ Nearly every day
  - b. Feeling depressed or hopeless? ☐ Not at all ☐ Several days  
☐ More than half of the month  
☐ Nearly every day
10. Tobacco Products
  - a. Do you smoke (including cigarettes, pipes, cigars, or e-cigarettes)? ☐ Current smoker ☐ Quit (1-12 months ago)  
☐ Quit (More than 12 months ago)  
☐ Never Smoked
  - b. Tobacco cessation activity completed. ☐ Yes ☐ No  
☐ Discontinued activity  
☐ Not sure

### C. Survey of Services Rendered

- |                                                                       |                              |                             |
|-----------------------------------------------------------------------|------------------------------|-----------------------------|
| Has the WISEWOMAN Program improved the quality of your life?          | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Are you satisfied with the services offered by the WISEWOMAN Program? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

### D. Clinical Measurements

#### TO BE COMPLETED BY CLINICIAN

|                                                                                                                                                                                                         |                                                                                                                                                                         |                        |                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| BMI: _____                                                                                                                                                                                              | Height: _____                                                                                                                                                           | Weight: _____ lbs.     | Waist circumference: _____<br>Hip circumference: _____ Ratio: _____                                                                                                                                                                                                          |
| BP 1 <sup>st</sup> _____/_____                                                                                                                                                                          | BP 2 <sup>nd</sup> _____/_____                                                                                                                                          | Average BP _____/_____ | Hypertension Follow-up (>130/80)<br><input type="checkbox"/> Medical Follow-up<br><input type="checkbox"/> Health Coaching <input type="checkbox"/> SMBP <input type="checkbox"/> Client Refused                                                                             |
| <input type="checkbox"/> Labs Not Done <input type="checkbox"/> Fasting (9-12 hours) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> BMP <input type="checkbox"/> CMP |                                                                                                                                                                         |                        |                                                                                                                                                                                                                                                                              |
| <input type="checkbox"/> A1C                                                                                                                                                                            | LIPID PANEL (Fasting only)<br><input type="checkbox"/> Total Cholesterol <input type="checkbox"/> HDL                                                                   |                        | <input type="checkbox"/> LDL <input type="checkbox"/> Triglycerides                                                                                                                                                                                                          |
| RISK REDUCTION COUNSELING:                                                                                                                                                                              | <input type="checkbox"/> Healthy Eating <input type="checkbox"/> Physical Activity<br><input type="checkbox"/> Smoking Cessation <input type="checkbox"/> BP Management |                        | LSP Referral: <input type="checkbox"/> ESBA <input type="checkbox"/> DPP <input type="checkbox"/> TOPS<br><input type="checkbox"/> Tobacco Quitline <input type="checkbox"/> Weight Watchers<br><input type="checkbox"/> Health Coaching <input type="checkbox"/> Other HBSS |
|                                                                                                                                                                                                         | <input type="checkbox"/> SMBP                                                                                                                                           |                        |                                                                                                                                                                                                                                                                              |

COMMENTS: