

WISEWOMAN Health Assessment

Please answer the questions below about your health history, nutrition and physical activity habits. The information that you provide will help you and your physician determine if your lifestyle makes you at risk for developing heart disease. The information will also be used to create an action plan on how to make small changes in your life to help reduce your risk of developing heart disease.

Health History	<p>1. Do you have any of the following conditions?</p> <p>a. Hypertension (high blood pressure): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p> <p>b. High cholesterol: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p> <p>c. Diabetes (type 1 or 2): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p>
Blood Pressure	<p>If you answered yes to being diagnosed with high blood pressure:</p> <p>1. Have you ever been prescribed medication to lower your blood pressure?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p> <p>a. If you answered yes to #1, during the past 7 days, on how many days did you take the prescribed medication to lower your blood pressure?</p> <p>_____ Number of days <input type="checkbox"/> None <input type="checkbox"/> Not Applicable <input type="checkbox"/> Don't Know/Not Sure</p> <p><input type="checkbox"/> Don't want to answer</p> <p>b. If you answered yes to #1, have you had your blood pressure re-measured by a healthcare provider or another community resource after being prescribed medication?</p> <p><input type="checkbox"/> Yes (Date of measurement: __/__/____) <input type="checkbox"/> No</p> <p>2. Do you measure your blood pressure at home or using other calibrated sources?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No, was never told to measure blood pressure <input type="checkbox"/> No, don't know how to measure blood pressure <input type="checkbox"/> No, don't have equipment to measure blood pressure <input type="checkbox"/> Don't Know/ Not Sure</p> <p><input type="checkbox"/> Don't want to answer</p> <p>a. If you answered yes to #2, how often do you measure your blood pressure at home or using other calibrated sources?</p> <p><input type="checkbox"/> Multiple times per day <input type="checkbox"/> Daily <input type="checkbox"/> A few times per week <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly</p> <p><input type="checkbox"/> Don't Know/ Not Sure <input type="checkbox"/> Don't want to answer</p> <p>b. Do you regularly share blood pressure readings with a health care provider for feedback?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p>
Cholesterol	<p>If you answered yes to being diagnosed with high cholesterol:</p> <p>1. Has medication (Statin) ever been prescribed to lower your cholesterol?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p> <p>2. Has medication (other than Statin) ever been prescribed to lower your cholesterol?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p> <p>3. During the past 7 days, how many days did you take the prescribed medication to lower your cholesterol? _____ Number of days <input type="checkbox"/> None <input type="checkbox"/> Not Applicable <input type="checkbox"/> Don't Know/Not Sure</p> <p><input type="checkbox"/> Don't want to answer</p>
Diabetes	<p>If you answered yes to being diagnosed with diabetes (Type 1 or Type 2):</p> <p>1. Has medication ever been prescribed to lower your blood sugar?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p> <p>a. During the past 7 days, how many days did you take the prescribed medication to lower your blood sugar? _____ Number of days <input type="checkbox"/> None <input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Don't Know/Not Sure <input type="checkbox"/> Don't want to answer</p>

Provider NPI: _____ Office Visit Date: _____

<p>Cardiac</p>	<p>1. Have you had or been diagnosed by a health care provider as having any of these:</p> <p>a. Stroke/TIA <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p> <p>b. Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p> <p>c. Coronary heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p> <p>d. Heart Failure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p> <p>e. Vascular (peripheral arterial) disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p> <p>f. Congenital heart disease/defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p> <p>2. Are you taking aspirin daily to help prevent a heart attack or stroke?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/Not sure <input type="checkbox"/> Don't want to answer</p>
<p>Nutrition</p>	<p>1. How many cups of fruits and vegetable do you eat in an average day?</p> <p>_____ Number of cups <input type="checkbox"/> None <input type="checkbox"/> Don't Know/Not Sure <input type="checkbox"/> Don't want to answer</p> <p>2. Do you eat fish at least two times a week? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p> <p>3. Thinking about all the servings of grain products you eat in a typical day, how many are whole grains? <input type="checkbox"/> Less than half <input type="checkbox"/> About half <input type="checkbox"/> More than half <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p> <p>4. Do you drink less than 36 ounces (450 calories) of sugar-sweetened beverage weekly?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p> <p>5. Are you currently watching or reducing your sodium or salt intake?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Don't want to answer</p> <p>6. In the past 7 days, how often have you had a drink containing alcohol?</p> <p>_____ Number of days <input type="checkbox"/> None <input type="checkbox"/> Don't Know/ Not Sure <input type="checkbox"/> Don't want to answer</p> <p>7. How many alcoholic drinks, on average, do you consume during a day you drink?</p> <p>_____ Number of drinks <input type="checkbox"/> None <input type="checkbox"/> Don't Know/ Not Sure <input type="checkbox"/> Don't want to answer</p>
<p>Physical Activity</p>	<p>1. How many minutes of physical activity (exercise) do you get in a week?</p> <p>_____ Number of minutes <input type="checkbox"/> None <input type="checkbox"/> Don't Know/ Not Sure <input type="checkbox"/> Don't want to answer</p>
<p>Other</p>	<p>1. Do you smoke? Includes cigarettes, pipes, cigars, or e-cigarettes (smoked tobacco in any form)</p> <p><input type="checkbox"/> Current Smoker <input type="checkbox"/> Quit (1-12 months ago) <input type="checkbox"/> Quit (more than 12 months ago)</p> <p><input type="checkbox"/> Never Smoked <input type="checkbox"/> Don't want to answer</p> <p>2. Over the past 2 weeks, how often have you:</p> <p>a. Had little interest or pleasure in doing things?</p> <p><input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half <input type="checkbox"/> Nearly every day</p> <p><input type="checkbox"/> Don't want to answer</p> <p>b. Felt down, depressed, or hopeless?</p> <p><input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half <input type="checkbox"/> Nearly every day</p> <p><input type="checkbox"/> Don't want to answer</p> <p>3. Within the past 12 months, I worried about whether my food would run out before I got money to buy more.</p> <p><input type="checkbox"/> Often True <input type="checkbox"/> Sometimes True <input type="checkbox"/> Never True <input type="checkbox"/> Don't Know/Don't want to answer</p> <p>4. Within the past 12 months, the food we bought just didn't last and we didn't have money to get more. <input type="checkbox"/> Often True <input type="checkbox"/> Sometimes True <input type="checkbox"/> Never True <input type="checkbox"/> Don't Know/Don't want to answer</p>