Provider NPI: ____________________ Office Visit Date: ___________

WELL-AHEAD WELLAHEADLA.COM WISEWOMAN

Clinical Measures and Healthy Behavior Support Service Referrals

Height (0'0") ________ Weight (lbs.) _______ Waist Circumference (inches) _________

<table>
<tr><td>Screening Information</td><td colspan="2">1. Number of WISEWOMAN screening cycles received by participant: ____________
2. Type of screening visit: ☐ Screening ☐ Rescreening ☐ Follow-up Assessment–LSP/HC complete
☐ Follow-up Assessment-LSP/HC incomplete
3. What funds were used to pay for navigation services?
☐ NBCCEDP ☐ WISEWOMAN ☐ Indian Health Services/tribal funds ☐ Other
4. Did any follow-up screening (between 3 and no later than 11 months after the previous baseline screening/rescreening and within 4 to 6 weeks after LSP/HC completion) occur at the site? ☐ Yes ☐ No</td></tr>
<tr><td>Blood Pressure</td><td colspan="2">Date of reading: ____/____/______ BP Reading: ________/________mm Hg
2nd BP Reading (optional): ________/________mm Hg
<u>Alert/BP Disease Level (systolic > 180 or diastolic >120) Follow-Up</u>:
☐ Medically necessary, date of follow-up: ____/____/______ ☐ Not medically necessary
☐ Medically necessary, but declined ☐ Participant refused</td></tr>
<tr><td>Cholesterol and Lipids</td><td>Fasting (at least 9 hours)? ☐ Yes ☐ No
Total Cholesterol: ___________mg/dL
HDL Cholesterol: ___________mg/dL
LDL Cholesterol: ___________mg/dL
Triglycerides: ___________mg/dL
For non-fasting participants who are NOT on a lipid-lowering drug therapy and do NOT have a history of high cholesterol, if triglyceride reading was >0400 mg/dL, repeat the lipid panel within 30 days to obtain the fasting values.</td><td><u>If no cholesterol, check reason</u>
☐ Inadequate sample
☐ Participant refused
☐ No measurement recorded
<u>If no triglyceride, check reason</u>
☐ Participant taking lipid-lowering drug therapy
☐ Participant has history of high cholesterol
☐ Reading was >0400 mg/dL</td></tr>
<tr><td>HgA1C/ Glucose Testing</td><td>Fasting (at least 9 hours)? ☐ Yes ☐ No
<u>Only complete one of the following measures.</u>
<u>HgA1C for diabetes monitoring only by POC</u>:
HgA1C by POC: ___________%
<u>Non-Diabetic Participants Only</u>:
Fasting Glucose: __________mg/dL
<u>Diabetes Screening</u>:
HgA1C by venipuncture: __________%</td><td><u>If no HgA1C test, check reason</u>
☐ Inadequate sample
<u>If no fasting glucose test, check reason</u>
☐ Inadequate sample</td></tr>
</table>

Provider NPI: ____________________ Office Visit Date: ___________

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Screening Period (check one)	☐ Period 1 Year 1 (09/30/2023 and 03/31/2024) ☐ Period 2 Year 1 (04/01/2024 and 09/29/2024) ☐ Period 1 Year 2 (09/30/2024 and 03/31/2025) ☐ Period 2 Year 2 (04/01/2025 and 09/29/2025) ☐ Period 1 Year 3 (09/30/2025 and 03/31/2026) ☐ Period 2 Year 3 (04/01/2026 and 09/29/2026) ☐ Period 1 Year 4 (09/30/2026 and 03/31/2027) ☐ Period 2 Year 4 (04/01/2027 and 09/29/2027) ☐ Period 1 Year 5 (09/30/2027 and 03/31/2028) ☐ Period 2 Year 5 (04/01/2028 and 09/29/2028)
Risk Reduction Counseling	1. Has the participant completed risk reduction counseling? ☐ Yes, date of completion: ____/____/______ ☐ No, participant refused program contact ☐ No, participant did not respond after three attempts to contact 2. Have you discussed CVD risk factors? ☐ Yes ☐ No 3. Have you discussed roles of nutrition and physical activity? ☐ Yes ☐ No 4. Have you addressed medication adherences? ☐ Yes ☐ No
Lifestyle Program/ Health Coaching	1. Has the participant been referred to a lifestyle program or health coaching? ☐ Yes ☐ No Date of referral: ____/____/______ Name of program: ________________________ Program ID: ______ Additional programs referred to: Date of referral: ____/____/______ Name of program: ________________________ Program ID: ______ Date of referral: ____/____/______ Name of program: ________________________ Program ID: ______ ☐ None 2. How many lifestyle program or health coaching sessions has the participant received during the current screening cycle? ________ sessions 3. Please list all of the dates of lifestyle program or health coaching sessions completed by the participant since joining WISEWOMAN ____/____/______, ____/____/______, ____/____/______, ____/____/______, ____/____/______, ____/____/______, ____/____/______, ____/____/______
Tobacco cessation	1. Tobacco Cessation Resources referral date ____/____/______ a. Type of Tobacco Cessation Resource ☐ Quitline ☐ Community-based tobacco program ☐ Internet-based tobacco program ☐ Other tobacco cessation resources b. Tobacco Cessation Activity Completed ☐ Yes ☐ No, participant partially completed ☐ No, participant discontinued from tobacco cessation when contacted by the resource ☐ No, participant could not be reached by the resource 2. List any additional dates the participant was previously referred: ____/____/______, ____/____/______, ____/____/______, ____/____/______, ____/____/______, ____/____/______, ____/____/______

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	**1. Do you have any of the following conditions?** a. Hypertension (high blood pressure) ☐ Yes ☐ No b. High cholesterol ☐ Yes ☐ No c. Diabetes (type 1 or 2) ☐ Yes ☐ No
Blood Pressure	If you answered **yes** to being diagnosed with high blood pressure: **1. Have you ever been prescribed medication to lower your blood pressure?** ☐ Yes ☐ No 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?** ____ Number of days ☐ None 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?** ☐ Yes (Date of measurement: __/__/____) ☐ No **2. Do you measure your blood pressure at home or using other calibrated sources?** ☐ Yes ☐ No ☐ No, don't know how to measure blood pressure ☐ No, don't have equipment to measure blood pressure a. **If you answered yes to #2, how often do you measure your blood pressure at home or using other calibrated sources?** ☐ Multiple times per day ☐ Daily ☐ A few times per week ☐ Weekly ☐ Monthly b. **Do you regularly share blood pressure readings with a health care provider for feedback?** ☐ Yes ☐ No
Cholesterol	If you answered **yes** to being diagnosed with high cholesterol: **1. Has medication (Statin) ever been prescribed to lower your cholesterol?** ☐ Yes ☐ No **2. Has medication (other than Statin) ever been prescribed to lower your cholesterol?** ☐ Yes ☐ No **3. During the past 7 days, how many days did you take the prescribed medication to lower your cholesterol?** ______ Number of days ☐ None
Diabetes	If you answered **yes** to being diagnosed with diabetes (type 1 or type 2): **1. Has medication ever been prescribed to lower your blood sugar?** ☐ Yes ☐ No a. **During the past 7 days, how many days did you take the prescribed medication to lower your blood sugar?** ______ Number of days ☐ None ☐ Not Applicable
Cardiac	**1. Have you had or been diagnosed by a health care provider as having any of these?** a. Stroke/TIA ☐ Yes ☐ No b. Heart attack ☐ Yes ☐ No c. Coronary heart disease ☐ Yes ☐ No d. Heart Failure ☐ Yes ☐ No

<table>
<tr><td></td><td>
e. Vascular (peripheral arterial) disease ☐ Yes ☐ No
f. Congenital heart disease/defects ☐ Yes ☐ No
g. Gestational hypertension ☐ Yes ☐ No
h. Gestational diabetes ☐ Yes ☐ No
i. Pre-eclampsia/eclampsia ☐ Yes ☐ No
2. Are you taking aspirin daily to help prevent a heart attack or stroke?
☐ Yes ☐ No
</td></tr>
<tr><td>Nutrition</td><td>
1. How many cups of fruits and vegetable do you eat in an average day?
_______ Number of cups ☐ None
2. Do you eat fish at least two times a week? ☐ Yes ☐ No
3. Thinking about all the servings of grain products you eat in a typical day, how many are whole grains? ☐ Less than half ☐ About half ☐ More than half
4. Do you drink less than 36 ounces (450 calories) of sugar-sweetened beverage weekly?
☐ Yes ☐ No
5. Are you currently watching or reducing your sodium or salt intake?
☐ Yes ☐ No
6. In the past 7 days, how often have you had a drink containing alcohol?
_______ Number of days ☐ None
7. How many alcoholic drinks, on average, do you consume during a day you drink?
_______ Number of drinks ☐ None
</td></tr>
<tr><td>Physical Activity</td><td>
1. How many minutes of physical activity (exercise) do you get in a week?
_______ Number of minutes ☐ None
</td></tr>
<tr><td>Social</td><td>
1. Do you use any of the following types of electronic devices?
a. Desktop/Laptop ☐ Yes ☐ No
b. Smartphone ☐ Yes ☐ No
c. Tablet/Other portable wireless computer ☐ Yes ☐ No
2. Do you or any member of this household have access to the internet?
☐ Yes, by paying a cell phone company or internet service provider
☐ Yes, without paying a cell phone company or internet service provider
☐ No, do not have access to internet in this house, apartment, or mobile home
3. During the last 12 months, was there a time when you were worried you would run out of food because of a lack of money or other resources?
☐ Yes ☐ No
4. Have you ever missed a doctor's appointment because of transportation problems?
☐ Yes ☐ No
5. Type of Childcare Services
☐ Infant (Birth to 11 months) ☐ Toddler (11 to 36 months) ☐ Preschool (3 to 5 years)
☐ After School Care (K – 9th grade) ☐ Not Applicable
6. Have you had any of these child-care related problems during the past year? (Select all that apply)
☐ Cost ☐ Availability ☐ Location ☐Transportation ☐ Hours of Operation ☐ Other
☐ Not Applicable
7. What is your housing situation today?
☐ I have housing ☐ I have housing, however I am worried about losing my housing
☐ I do not have housing
</td></tr>
</table>

	8. **The following will ask about how safe you feel:** a. **How often does your partner physically hurt you?** ☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly Often ☐ Frequently b. **How often does your partner insult or talk down to you?** ☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly Often ☐ Frequently 9. **These four items are related to medication-taking adherence:** a. **Do you ever forget to take you medicine?** ☐ Yes ☐ No b. **Are you careless at times about taking your medicine?** ☐ Yes ☐ No c. **When you feel better, do you sometimes stop taking your medicine?** ☐ Yes ☐ No d. **Sometime if you feel worse when you take your medicine, do you stop taking it?** e. ☐ Yes ☐ No 10. **What social service(s) do you need?** **Social Service ID** ______________________________ ☐ Computer use ☐ Internet Access ☐ Food Insecurity ☐ Transportation ☐ Child Care ☐ Housing ☐ Intimate Partner Violence ☐ Medication Adherence ☐ Mental Health ☐ Language Translation ☐ Substance Abuse 11. **Social Service Referral Date:** ____ /____ /______, ____ /____ /______, ____ /____ /______, ____ /____ /______, ____ /____ /______, ____ /____ /______, ____ /____ /______, ____ /____ /______ **Date of Social Service and Support Utilization:** ____ /____ /______, ____ /____ /______, ____ /____ /______, ____ /____ /______, ____ /____ /______, ____ /____ /______, ____ /____ /______, ____ /____ /______
Other	1. **Do you smoke? Includes cigarettes, pipes, cigars, or e-cigarettes (smoked tobacco in any form)** ☐ Current Smoker ☐ Quit (1-12 months ago) ☐ Quit (more than 12 months ago) ☐ Never Smoked 2. **Over the past 2 weeks, how often have you:** a. **Had little interest or pleasure in doing things?** ☐ Not at all ☐ Several days ☐ More than half ☐ Nearly every day b. **Felt down, depressed, or hopeless?** ☐ Not at all ☐ Several days ☐ More than half ☐ Nearly every day 3. **Within the past 12 months, I worried about whether my food would run out before I got money to buy more.** ☐ Often True ☐ Sometimes True ☐ Never True 4. **Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.** ☐ Often True ☐ Sometimes True ☐ Never True