

Provider NPI: _____ Office Visit Date: _____

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.

<p>Health History</p>	<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</p> <p>b. High cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Diabetes (type 1 or 2) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Blood Pressure</p>	<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</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</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 <input type="checkbox"/> No, don't know how to measure blood pressure <input type="checkbox"/> No, don't have equipment to measure blood pressure</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>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</p>
<p>Cholesterol</p>	<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</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</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</p>
<p>Diabetes</p>	<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</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>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</p> <p>b. Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Coronary heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Heart Failure <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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

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	<p>8. Are you a care giver? i.e., Family: child, parent, elder. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you live in a multigenerational home? (Ex: Parents, adult children or grandparents, parents and children all in the same household.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. The following will ask about how safe you feel:</p> <p>a. How often does your partner physically hurt you? <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Fairly Often <input type="checkbox"/> Frequently</p> <p>b. How often does your partner insult or talk down to you? <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Fairly Often <input type="checkbox"/> Frequently</p> <p>11. These four items are related to medication-taking adherence:</p> <p>a. Do you ever forget to take you medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Are you careless at times about taking your medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. When you feel better, do you sometimes stop taking your medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Sometime if you feel worse when you take your medicine, do you stop taking it? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. What social service(s) do you need? Social Service ID _____</p> <p><input type="checkbox"/> Computer use <input type="checkbox"/> Internet Access <input type="checkbox"/> Food Insecurity <input type="checkbox"/> Transportation <input type="checkbox"/> Child Care <input type="checkbox"/> Housing <input type="checkbox"/> Intimate Partner Violence <input type="checkbox"/> Medication Adherence <input type="checkbox"/> Mental Health <input type="checkbox"/> Language Translation <input type="checkbox"/> Substance Abuse</p> <p>Social Service Referral Date: ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____</p> <p>Date of Social Service and Support Utilization: ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____</p>
<p>Other</p>	<p>1. Do you smoke? Includes cigarettes, pipes, cigars, or e-cigarettes (smoked tobacco in any form) <input type="checkbox"/> Current Smoker <input type="checkbox"/> Quit (1-12 months ago) <input type="checkbox"/> Quit (more than 12 months ago) <input type="checkbox"/> Never Smoked</p> <p>2. Over the past 2 weeks, how often have you:</p> <p>a. Had little interest or pleasure in doing things? <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>b. Felt down, depressed, or hopeless? <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>3. Within the past 12 months, I worried about whether my food would run out before I got money to buy more. <input type="checkbox"/> Often True <input type="checkbox"/> Sometimes True <input type="checkbox"/> Never True</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</p>