Alabama WISEWOMAN Clinical Data Collection Form:Baseline/Risk Reduction

Provider Name _____ **Tracking Number:** | | | | | | | | | | | |

Date _____ **First Name** _____ **Last Name** _____ **DOB:** _____

Address _____ **City:**_____ **State:**____ **Zip Code:**_____

Education: 1 2 3 4 5 6 7 8 9 10 11 12, College 1 2 3 4 Don't Want to Answer High School Diploma/GED: Yes No

Race: Unknown White Black/AA Native Hawaiian/Pacific Islander American Indian/Alaska Native

Other Race: _____ **If Applicable, Second Race:**_____

Hispanic Origin: Yes No Language: English Spanish Other: _____ **Phone:** (____)_____

Hypertension	1. Do you have hypertension (high blood pressure) Yes ___ , No ___ , Don't Know/Not Sure ___
	2. Was medication prescribed to lower your blood pressure? Yes ___ , No ___
	3. Do you measure your blood pressure at home or using other calibrated sources? Yes ___ , No –Was Not Told___ , No-Doesn't know how ___ , No-Doesn't have equipment___ , N/A___
	4. How often do you measure your blood pressure at home or using other calibrated sources? Multiple times per day ___ , Daily___ , Few Times Per Week ___ , Weekly ___ , Monthly ___
	5. During the past 7 days, on how many days did you take medication to lower your blood pressure? Number of Days ___ , None ___
	6. Do you regularly share blood pressure readings with a health care provider for feedback? Yes ___ , No ___
Cholesterol	7. Do you have high cholesterol? Yes ___ , No ___ , Don't Know/Not Sure ___
	8. Was medication (Statin) prescribed to lower your cholesterol? Yes ___ , No ___
	9. Was medication (other than Statin) prescribed to lower your cholesterol? Yes ___ , No ___
	10. During the past 7 days, on how many days did you take prescribed medications to lower your cholesterol? Number of Days ___ , None ___
Diabetes	11. Do you have diabetes? Yes ___ , No ___ , Don't Know/Not Sure ___
	12. Was medication prescribed to lower your blood sugar? Yes ___ , No ___
	13. During the past 7 days, on how many days did you take prescribed medication to lower blood sugar? Number of Days ___ , None ___
Heart Health	14. Have you had a stroke/TIA? Yes ___ No ___ Don't Know/Not Sure ___
	15. Have you had a heart attack? Yes ___ No ___ Don't Know/Not Sure ___
	16. Have you had heart disease? Yes ___ No ___ Don't Know/Not Sure ___
	17. Have you had heart failure? Yes ___ No ___ Don't Know/Not Sure ___
	18. Have you had vascular disease? Yes ___ No ___ Don't Know/Not Sure ___
	19. Have you had congenital heart disease? Yes ___ No ___ Don't Know/Not Sure ___

Health Assessment

20. Are you taking aspirin daily to help prevent a heart attack or stroke? Yes ___ , No ___
21. How many cups of fruits and vegetables do you eat in an average day? Number of cups ___ , None ___
22. Do you eat fish at least two times a week? Yes ___ , No ___
23. 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 ___
24. Do you drink less than 36 ounces (450 calories) of sugared sweetened beverages weekly? Yes ___ , No ___
25. Are you currently watching or reducing your sodium or salt intake? Yes ___ , No ___
26. How many minutes of physical activity (exercise) do you get in a week? Number of minutes ___ , None ___
27. Do you smoke? Include cigarettes, pipes, or cigars (smoked tobacco in any form} Current Smoker ___ , Quit (1-12 months ago) ___ , Quit(more than 12 months ago) ___, Never Smoked ___
28. Over the past two weeks, how often have you been bothered by little interest or pleasure in doing things? Not at all ___ , Several days ___ , More than half ___ , Nearly every day ___
29. Over the past 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless? Not at all ___ , Several days ___ , More than half ___ , Nearly every day ___
30. In the past 7 days, how often do you have a drink containing alcohol? Number of Days ___ , None ___
31. How many alcoholic drinks, on average, do you consume during a day you drink? Number ___ , None ___

For Clinical Staff Only: **Screening Date:** _____

Patient: _____ **Tracking Number:** _____

Height : _____ **in**	**Weight:**_____**lbs**	**BMI:**_____	**Waist:** _____**in.**	**Is Patient Fasting? Yes ☐ No ☐**

Measurements Tab

1st BP Reading:	_____/ _____ **mm Hg**
2nd BP Reading:	_____/ _____ **mm Hg**
Average BP Reading:	_____/ _____ **mm Hg**

Blood Pressure Alert

***Alert BP: Systolic >180 OR Diastolic > 120 mm Hg**

Alert Action: Requires immediate medical evaluation

Medically Necessary ☐ BP Alert Date: _____ **BP Alert Follow-Up Date:** _____

Not Medically Necessary ☐

Medically Necessary Follow-Up Appointment Declined ☐

Client Refused Work-up ☐

Blood Work Tab

Cholesterol

Total Cholesterol-Fasting or Non-Fasting	_____**mg/dl**
HDL Cholesterol-Fasting or Non-Fasting	_____**mg/dl**
LDL Cholesterol-Fasting Only	_____**mg/dl**
Trigylcerides-Fasting Only	_____**mg/dl**

Blood Glucose

***Alert Fasting Glucose: ≤ 50 OR ≥250 mg/dl**

Blood Glucose-Fasting	**A1c Percentage**:
Test Result: _____ **mg/dl**	**% Test Result:** _____
Why No Test: _____	**Why No Test:** _____

Risk Reduction Counseling Session: **Start Date:** _____ **Completion Date:** _____

Health Coaching Referral Date: _____ **If Not Referred, Why:** _____

Has staff reviewed patient's hypertension medication adherence plan?	**Yes**	**No**	**Not Applicable**
Did patient receive home blood pressure monitor for Stage 2 Hypertension?	**Yes**	**No**	**Not Applicable**

Adjusted Medication Plan

Was patient prescribed a new medication for hypertension today?	**Yes**	**No**	**Not Applicable**
Was patient prescribed a new medication for cholesterol today?	**Yes**	**No**	**Not Applicable**
Was patient prescribed a new medication for diabetes today?	**Yes**	**No**	**Not Applicable**