

WISEWOMAN Annual Screening Form DHHS 4049A		Agency:	
1. Patient Identification		Patient Name: Last _____ First _____ M.I. _____	
HIS ID (CNDS): _____		Date of Birth: ____/____/____	Inactive Date: ____/____/____
Enrollment Status: <input type="checkbox"/> Active <input type="checkbox"/> Has Insurance <input type="checkbox"/> Moved <input type="checkbox"/> Age Ineligible <input type="checkbox"/> Income Ineligible <input type="checkbox"/> Lost To Follow-up <input type="checkbox"/> Deceased <input type="checkbox"/> Request to Drop			
Years of education: <input type="checkbox"/> <9 th grade <input type="checkbox"/> Some high school <input type="checkbox"/> High school grad. or equiv. <input type="checkbox"/> Some college or higher <input type="checkbox"/> Don't know <input type="checkbox"/> Don't want to answer			
2. Patient Enrollment/Annual Screening		3. Primary Language Spoken at Home	
Date of screening ____/____/____ Visit Type: <input type="checkbox"/> New Enrollee <input type="checkbox"/> Rescreening (12 – 18 months)		<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Arabic <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> Italian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Polish <input type="checkbox"/> Russian <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese <input type="checkbox"/> Creole <input type="checkbox"/> Portuguese <input type="checkbox"/> Hmong <input type="checkbox"/> Other Language <input type="checkbox"/> Don't want to answer	
Clinical Measurement Results (777=Unable to Obtain, 888=Client Refused) (for Height, Hip, & Waist: 77=Unable to Obtain, 88=Client Refused) (for A1C & Triglycerides 7777=Unable to Obtain, 8888=Client Refused)			
Height (inches) _____		Weight (pounds) _____	
_____		_____	
Waist Circumference (inches) _____		Hip Circumference (inches) _____	
_____		_____	
Blood Pressure Measurement Date ____/____/____		1 st Reading ____/____	
_____		_____	
_____		2 nd Reading ____/____	
_____		_____	
Blood Draw Date ____/____/____		Fasting Status (at least 9 hrs.) <input type="checkbox"/> Fasting <input type="checkbox"/> Non-fasting	
_____		_____	
Total Cholesterol _____	HDL _____	LDL (requires fasting) _____	Triglycerides (requires fasting) _____
_____		_____	
_____		A1C (recommended for diabetics and non-fasting) _____	
_____		_____	
_____		Glucose (requires fasting) _____	
_____		_____	
Workup Status (Alert) Status: 1-Complete, 2-Follow-up with alternate physician, 3-Not Alert Reading, 8-Client-refused, 9-Lost to Follow-Up			
Blood Pressure Exam Date ____/____/____ Status _____		Blood Glucose Exam Date ____/____/____ Status _____	
_____		_____	
Comments:			
4. Medical History (DKNS=don't know/not sure, DWTA=don't want to answer)		5. Medication Status (CNO= Could not Obtain Medication, NA/55=Not Applicable, 0=None, DKNS/77=don't know/not sure, DWTA/88=don't want to answer)	
a. Do you have high cholesterol ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA b. Do you have hypertension (high blood pressure)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA c. Do you have Diabetes (either Type 1 or Type 2)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA d. Have you been diagnosed as having any of these conditions: coronary heart disease/chest pain, heart attack, heart failure, stroke/transient ischemic attack (TIA), vascular disease, or congenital heart defects? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA		a. Do you take medication to lower your cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CNO <input type="checkbox"/> NA <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA b. Do you take medication to lower your blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CNO <input type="checkbox"/> NA <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA c. Are you taking medication to lower your blood sugar (for diabetes)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CNO <input type="checkbox"/> NA <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA d. During the past 7 days, on how many days did you take prescribed medications to lower your cholesterol? _____ (number of days) e. During the past 7 days, on how many days did you take prescribed medication (including diuretics) to lower your blood pressure? _____ (number of days) f. During the past 7 days, on how many days did you take prescribed medication to lower blood sugar (for diabetes)? _____ (number of days)	
6. Blood Pressure, Self-Measurement (at Home or using other calibrated sources)(Only for patients with hypertension)			
a. Do you measure your blood pressure? <input type="checkbox"/> Not Applicable <input type="checkbox"/> Yes <input type="checkbox"/> No-Was never told to measure blood pressure <input type="checkbox"/> No-Doesn't know how to measure blood pressure <input type="checkbox"/> No-Doesn't have equipment <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA b. How often do you measure your blood pressure? <input type="checkbox"/> Not Applicable <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 <input type="checkbox"/> Other <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA c. Do you regularly share blood pressure readings with a health care provider for feedback? <input type="checkbox"/> Not Applicable <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA			

Patient Identification HIS ID (CNDS): _____

Patient Name: Last _____ First _____ M.I. _____

7. Nutrition Assessment
(00=None, 88=Don't want to answer, DWTA=don't want to answer)

- a. How much fruit do you eat in an average day _____ (in cups)
- b. How many vegetables do you eat in an average day _____ (in cups)
- c. Do you eat two servings or more of fish weekly? Yes No DWTA
- d. Do you eat 3 ounces or more of whole grains daily? Yes No DWTA
- e. Do you drink less than 36 ounces (450 calories) of beverages with added sugars weekly? Yes No DWTA
- f. Are you currently watching or reducing your sodium or salt intake? Yes No DWTA

8. Physical Activity Assessment
(000=None, 888=Don't want to answer)

- a. How much moderate physical activity do you get in a week? _____ (in minutes)
- b. How much vigorous physical activity do you get in a week? _____ (in minutes)

9. Smoking status (66=less than one, 88=don't want to answer, 00=none)

- a. Do you smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form)
Current Quit (1-12 months ago) Quit(>12 months ago) Never Smoked DWTA
- b. About how many hours a day, on average, are you in the same room or vehicle with another person who is smoking? _____ (in hours)

10. Quality of Life Assessment (77=Don't know/Not Sure, 88=Don't want to answer)

- a. Thinking about your physical health, which includes physical illness and injury, on how many days during the past 30 days was your physical health not good? _____ (number of days)
- b. Thinking about your mental health, which includes stress, depression, and problems with emotions, on how many days during the past 30 days was your mental health not good? _____ (number of days)
- c. During the past 30 days, on about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? _____ (number of days)

17. Risk Reduction Counseling & Readiness to Change Assessment

Counseling Date ____/____/____ 30-60 Day Follow-Up Counseling Date ____/____/____ (if necessary)

Participant Priority Area	Stage of Change					
Nutrition <input type="checkbox"/> Yes <input type="checkbox"/> No	<table border="1" style="width: 100%; text-align: center;"> <tr> <td>1 Pre-Contemplation</td> <td>2 Contemplation</td> <td>3 Preparation</td> <td>4 Action</td> <td>5 Maintenance</td> </tr> </table>	1 Pre-Contemplation	2 Contemplation	3 Preparation	4 Action	5 Maintenance
1 Pre-Contemplation		2 Contemplation	3 Preparation	4 Action	5 Maintenance	
Physical Activity <input type="checkbox"/> Yes <input type="checkbox"/> No						
Smoking Cessation <input type="checkbox"/> Yes <input type="checkbox"/> No						
Medication Adherence for Hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No						

20. Tobacco Cessation Resource Referral Referral Date ____/____/____

Type of Cessation Resource	Status of Cessation Resource
<input type="checkbox"/> Quit Line <input type="checkbox"/> Community-based tobacco program <input type="checkbox"/> Other tobacco cessation resources	<input type="checkbox"/> Yes - Completed Tobacco Cessation Program <input type="checkbox"/> No - Partially completed Tobacco Cessation Program <input type="checkbox"/> No - Refused Tobacco Cessation Program <input type="checkbox"/> No - Could not use Tobacco Cessation Program

WISEWOMAN Health Coaching Form DHHS 4050A

Agency: _____

Patient Identification

HIS ID (CNDS): _____

Patient Name: Last _____

First _____

M.I. _____

19. Lifestyle Program (LSP) / Health Coaching (HC)

Referral Date ____/____/____ Community-Based Program

LSP/HC Visit Date	LSP/HC ID Diabetes Prevention Program (DPP) Eat Smart, Move More, Weight Less (WL)	Length of Session in minutes	Contact Type	Program Completion Status	LSP/HC Setting
____/____/____	<input type="checkbox"/> A New Leaf <input type="checkbox"/> Weight Watchers <input type="checkbox"/> TOPS <input type="checkbox"/> DPP <input type="checkbox"/> WL		<input type="checkbox"/> Face-to-Face <input type="checkbox"/> Phone <input type="checkbox"/> Online	<input type="checkbox"/> Completed <input type="checkbox"/> In Progress <input type="checkbox"/> Withdrawal/Discontinued	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Combination
____/____/____	<input type="checkbox"/> A New Leaf <input type="checkbox"/> Weight Watchers <input type="checkbox"/> TOPS <input type="checkbox"/> DPP <input type="checkbox"/> WL		<input type="checkbox"/> Face-to-Face <input type="checkbox"/> Phone <input type="checkbox"/> Online	<input type="checkbox"/> Completed <input type="checkbox"/> In Progress <input type="checkbox"/> Withdrawal/Discontinued	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Combination
____/____/____	<input type="checkbox"/> A New Leaf <input type="checkbox"/> Weight Watchers <input type="checkbox"/> TOPS <input type="checkbox"/> DPP <input type="checkbox"/> WL		<input type="checkbox"/> Face-to-Face <input type="checkbox"/> Phone <input type="checkbox"/> Online	<input type="checkbox"/> Completed <input type="checkbox"/> In Progress <input type="checkbox"/> Withdrawal/Discontinued	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Combination
____/____/____	<input type="checkbox"/> A New Leaf <input type="checkbox"/> Weight Watchers <input type="checkbox"/> TOPS <input type="checkbox"/> DPP <input type="checkbox"/> WL		<input type="checkbox"/> Face-to-Face <input type="checkbox"/> Phone <input type="checkbox"/> Online	<input type="checkbox"/> Completed <input type="checkbox"/> In Progress <input type="checkbox"/> Withdrawal/Discontinued	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Combination
____/____/____	<input type="checkbox"/> A New Leaf <input type="checkbox"/> Weight Watchers <input type="checkbox"/> TOPS <input type="checkbox"/> DPP <input type="checkbox"/> WL		<input type="checkbox"/> Face-to-Face <input type="checkbox"/> Phone <input type="checkbox"/> Online	<input type="checkbox"/> Completed <input type="checkbox"/> In Progress <input type="checkbox"/> Withdrawal/Discontinued	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Combination
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____/____/____	<input type="checkbox"/> A New Leaf <input type="checkbox"/> Weight Watchers <input type="checkbox"/> TOPS <input type="checkbox"/> DPP <input type="checkbox"/> WL		<input type="checkbox"/> Face-to-Face <input type="checkbox"/> Phone <input type="checkbox"/> Online	<input type="checkbox"/> Completed <input type="checkbox"/> In Progress <input type="checkbox"/> Withdrawal/Discontinued	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Combination
____/____/____	<input type="checkbox"/> A New Leaf <input type="checkbox"/> Weight Watchers <input type="checkbox"/> TOPS <input type="checkbox"/> DPP <input type="checkbox"/> WL		<input type="checkbox"/> Face-to-Face <input type="checkbox"/> Phone <input type="checkbox"/> Online	<input type="checkbox"/> Completed <input type="checkbox"/> In Progress <input type="checkbox"/> Withdrawal/Discontinued	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Combination
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____/____/____	<input type="checkbox"/> A New Leaf <input type="checkbox"/> Weight Watchers <input type="checkbox"/> TOPS <input type="checkbox"/> DPP <input type="checkbox"/> WL		<input type="checkbox"/> Face-to-Face <input type="checkbox"/> Phone <input type="checkbox"/> Online	<input type="checkbox"/> Completed <input type="checkbox"/> In Progress <input type="checkbox"/> Withdrawal/Discontinued	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Combination
____/____/____	<input type="checkbox"/> A New Leaf <input type="checkbox"/> Weight Watchers <input type="checkbox"/> TOPS <input type="checkbox"/> DPP <input type="checkbox"/> WL		<input type="checkbox"/> Face-to-Face <input type="checkbox"/> Phone <input type="checkbox"/> Online	<input type="checkbox"/> Completed <input type="checkbox"/> In Progress <input type="checkbox"/> Withdrawal/Discontinued	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Combination
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WISEWOMAN Post LSP/HC Follow-Up Assessment Form DHHS 4050B		Agency:
Patient Identification		HIS ID (CNDS):
Patient Name: Last		First M.I.
2. Patient Follow-Up Visit Type		Date of Follow-Up ____/____/____ <input type="checkbox"/> Follow-up – LSP/HC complete <input type="checkbox"/> Follow-up – LSP/HC incomplete
5. Medication Status (CNO= Could not Obtain, NA=Not Applicable, DKNS=don't know/not sure, DWTA=don't want to answer)		6. Blood Pressure Self Measurement (at Home or using other calibrated sources) (Only for patients with hypertension)
<p>a. Do you take medication to lower your cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CNO <input type="checkbox"/> NA <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA</p> <p>b. Do you take medication to lower your blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CNO <input type="checkbox"/> NA <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA</p> <p>c. Are you taking medication to lower your blood sugar (for diabetes)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CNO <input type="checkbox"/> NA <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA</p>		<p>a. Do you measure your blood pressure? <input type="checkbox"/> Not Applicable <input type="checkbox"/> Yes <input type="checkbox"/> No-Was never told to measure blood pressure <input type="checkbox"/> No-Doesn't know how to measure blood pressure <input type="checkbox"/> No-Doesn't have equipment <input type="checkbox"/> DK/NS <input type="checkbox"/> DWTA</p> <p>b. How often do you measure your blood pressure? <input type="checkbox"/> Not Applicable <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 <input type="checkbox"/> Other <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA</p> <p>c. Do you regularly share blood pressure readings with a health care provider for feedback? <input type="checkbox"/> Not Applicable <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA</p>
7. Nutrition Assessment (00=None, 88=Don't want to answer, DWTA=don't want to answer)		8. Physical Activity Assessment (000=None, 888=Don't want to answer)
<p>a. How much fruit do you eat in an average day _____ (in cups)</p> <p>b. How many vegetables do you eat in an average day _____ (in cups)</p> <p>c. Do you eat two servings or more of fish weekly? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DWTA</p> <p>d. Do you eat 3 ounces or more of whole grains daily? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DWTA</p> <p>e. Do you drink less than 36 ounces (450 calories) of beverages with added sugars weekly? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DWTA</p> <p>f. Are you currently watching or reducing your sodium or salt intake? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DWTA</p>		<p>a. How much moderate physical activity do you get in a week? _____ (in minutes)</p> <p>b. How much vigorous physical activity do you get in a week? _____ (in minutes)</p>
9. Smoking status (66=less than one, 88=don't want to answer, 00=none)		
<p>a. Do you smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form) <input type="checkbox"/> Current <input type="checkbox"/> Quit (1-12 months ago) <input type="checkbox"/> Quit(>12 months ago) <input type="checkbox"/> Never Smoked <input type="checkbox"/> DWTA</p> <p>b. About how many hours a day, on average, are you in the same room or vehicle with another person who is smoking? _____ (in hours)</p>		
10. Quality of Life Assessment (77=Don't know/Not Sure, 88=Don't want to answer)		
<p>a. Thinking about your physical health, which includes physical illness and injury, on how many days during the past 30 days was your physical health not good? _____ (number of days)</p> <p>b. Thinking about your mental health, which includes stress, depression, and problems with emotions, on how many days during the past 30 days was your mental health not good? _____ (number of days)</p> <p>c. During the past 30 days, on about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? _____ (number of days)</p>		