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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-01219 (09/2024) | **STATE OF WISCONSIN**  Bureau of Community Health Promotion  Chronic Disease Prevention and Cancer Control Section | | | | | | | |
| wisewoman health history assessment | | | | | | | | |
| SECTION 1 – CLIENT AND PROVIDER INFORMATION | | | | | | | | |
| 1. Provider Agency Name | | 2. Print Performing Provider Name | | | | 3. Date of Contact | | |
|  | |  | | | |  | | |
| 4. Client Name (Last, First MI) | | | 5. Date of Birth | | | 6. Client ID Number | | |
|  | | |  | | |  | | |
| **SECTION 2 – PERSONAL HEALTH HISTORY** | | | Yes | No | | Don’t Know or Not Sure | Not Applicable | |
| 1. Have you had any of the following: | | |
| * 1. Coronary heart disease | | |  |  | |  |  | |
| * 1. Heart attack | | |  |  | |  |  | |
| * 1. Heart failure | | |  |  | |  |  | |
| * 1. Vascular disease (peripheral arterial disease) | | |  |  | |  |  | |
| * 1. Stroke/TIA | | |  |  | |  |  | |
| * 1. Congenital heart disease and defects | | |  |  | |  |  | |
| 1. Are you taking aspirin daily to help prevent a heart attack or stroke? | | |  |  | |  |  | |
| 1. Have you had Gestational Hypertension? | | |  |  | |  |  | |
| 1. Have you had Gestational Diabetes? | | |  |  | |  |  | |
| 1. Have you had Preeclampsia/eclampsia? | | |  |  | |  |  | |
| 1. Do you have high cholesterol? | | |  |  | |  |  | |
| 1. Was medication **(Statin)** prescribed to lower your cholesterol? | | |  |  | |  |  | |
| 1. **Was medication (other than Statin) prescribed to lower your cholesterol**? | | |  |  | |  |  | |
| 1. During the past seven days on how many days did you take prescribed medication to lower your cholesterol? Number of Days: | | | | | | |  | |
| 1. Do you have diabetes (either type 1 or type 2)? | | |  |  | |  |  | |
| 1. Was medication prescribed to lower your blood sugar (for diabetes)? | | |  |  | |  |  | |
| 1. During the past seven days, on how many days did you take prescribed medication to lower your blood sugar (for diabetes)? Number of Days: | | | | | | |  | |
| 1. Do you have hypertension (high blood pressure)? | | |  |  | |  |  | |
| 1. Was medication prescribed to lower your blood pressure? | | |  |  | |  |  | |
| 1. During the past seven days, on how many days did you take prescribed medication (including diuretics/water pills) to lower your blood pressure? Number of Days: | | | | | | | | |
| 1. Do you measure your blood pressure at home or use other community-calibrated sources (for example, pharmacy or free blood pressure clinic)?  Yes  No   **If no, check all that apply:**  I was never told to measure blood pressure  I don’t know how to measure blood pressure  I don’t have equipment to measure blood pressure  Not Applicable | | | | | | | | |
| 1. How often do you measure your blood pressure at home or use other community-calibrated sources?   Multiple times per day  Daily  A few times a week  Weekly  Monthly  None  Not Applicable | | | | | | | | |
| 1. Do you regularly share blood pressure readings with a health care provider for feedback? | | |  | |  |  | |  |