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| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-01219 (09/2024) | **STATE OF WISCONSIN**Bureau of Community Health PromotionChronic 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?
 | [ ]  | [ ]  | [ ]  | [ ]  |

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| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-01220 (03/2019) | **STATE OF WISCONSIN**Bureau of Community Health PromotionChronic Disease Prevention and Cancer Control Section |
| wisewoman healthy lifestyle assessment |
| **SECTION 1 – CLIENT AND PROVIDER INFORMATION** |
| 1. Provider Agency Name | 2. Print Performing Provider Name | 3. Date of Integrated Office Visit |
|       |       |       |
| 4. Client Name (Last, First MI) | 5. Date of Birth | 6. Client ID Number |
|       |       |       |
| SECTION 2 – HEALTHY LIFESTYLE ASSESSMENT |
| 1. **How many cups of fruits and vegetables do you eat in an average day?**

      cups1. **Do you eat fish at least two times a week?**

[ ]  Yes [ ]  No1. **Thinking about all of the servings of grain products you eat in a typical day, how many are whole grains?**

[ ] Less than half [ ] About half [ ] More than half1. **Do you drink less than 36 ounces (450 calories) of sugar-sweetened beverages weekly?**

[ ]  Yes [ ]  No1. **Are you currently watching or reducing your sodium or salt intake?**

[ ]  Yes [ ]  No1. **In the past 7 days, how often did you have a drink containing alcohol?**

Number of days:       [ ] None1. **How many alcoholic drinks, on average, do you consume during a day you drink?**

Number of drinks:       [ ] None1. **How many minutes of physical activity (exercise) do you get in a week?**

Number of Minutes:       [ ]  None1. **Do you smoke?**

Includes cigarettes, pipes, or cigars (smoked tobacco in any form)[ ]  Current smoker [ ]  Quit 1-12 months ago [ ]  Quit more than 12 months ago [ ]  Never smoked1. **Over the past 2 weeks, how often have you been bothered by any of the following?**
	1. Little interest or pleasure in doing things:[ ]  0 – Not at all [ ]  1 – Several days [ ]  2 – More than half [ ]  3 – Nearly every day
	2. Feeling down, depressed, or hopeless:[ ]  0 – Not at all [ ]  1 – Several days [ ]  2 – More than half [ ]  3 – Nearly every day
 |

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| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-01221 (09/2024) | **STATE OF WISCONSIN**Bureau of Community Health PromotionChronic Disease Prevention and Cancer Control Section |
| wisewoman screening activity |
| **SECTION 1 – CLIENT AND PROVIDER INFORMATION** |
| 1. Provider Agency Name | 2. Print Performing Provider Name (NP, PA, or MD) | 3. Date of Contact |
|       |       |       |
| 4. Client Name (Last, First MI) | 5. Date of Birth | 6. Client ID Number |
|       |       |       |
| **SECTION 2 – MEDICAL HEART DISEASE AND STROKE RISK FACTOR(S)** |
| 1. Client Personal History (check all that apply)
 | Current Medication: |
| [ ]  High Blood Pressure[ ]  High Blood Cholesterol[ ]  Diabetes (Type 1 or Type 2) [ ]  Coronary Heart Disease[ ]  Heart Attack | [ ]  Heart Failure[ ]  Stroke (TIA)[ ]  Vascular Disease[ ]  Congenital Heart Defects[ ]  Gestational Diabetes[ ]  Gestational Hypertension[ ]  Preeclampsia/eclampsia | [ ]  Blood Pressure[ ]  Cholesterol (Statin)[ ]  Cholesterol (other than Statin)[ ]  Blood Sugar[ ]  Aspirin (used to prevent heart attack or stroke) |
| 1. Total number of minutes/week of physical activity:
 | 1. Total number of cups of fruits/vegetable daily:
 |
| 1. Tobacco Use: [ ]  Never smoked [ ]  Current smoker [ ]  Quit smoking
 |
| 1. Total number of alcoholic drinks consumed daily?

      | 1. Past two weeks, little interest or pleasure in doing things:

Depression Screening PHQ2 Score      PHQ9 Completed [ ]  Yes [ ]  No |
| SECTION 3 – CLINICAL MEASUREMENTS |
| 1. Height (feet) (inches)

            | 1. BP 1 Reading:

Right Arm     /      BP 2 Reading: Left Arm     /     \*Use the arm that gives the higher reading for subsequent measurements | \*Subsequent BP Arm:[ ]  Right [ ]  Left1. BP 3 Reading

     /     BP 4 Reading     /     Average of same arm readings     /      |
| 1. Weight (pounds)

      |
| 1. BMI

      |
| 1. Waist Circumference (inches)

      |
| SECTION 4 – LAB RESULTS |
| 1. Date of Fasting Lab Work (must be **fasting** for at least 9 hours):

     **NOTE:** If not fasting, reschedule appointment. | 1. Total Cholesterol
 | 1. HDL Cholesterol
 | 1. LDL Cholesterol
 | 1. Triglycerides
 |
|       mg/dL |       mg/dL |       mg/dL |       mg/dL |
| 1. Glucose
 | 1. A1c of Known Diabetic
 | 1. A1c Screening for High Risk
 |
|       mg/dL | Date | Percent | Date | Percent |
|       |       |       |       |
| 1. **Glucose**
 | [ ]  Impaired Fasting Glucose100-125 mg/dL or A1c 5.7%-6.4% | [ ]  Elevated≥126 mg/dL |
| 1. Does client have a confirmed medical diagnosis? Check all that apply:

[ ]  High Blood Pressure [ ]  Diabetes [ ]  High Cholesterol  |
| SECTION 5 – RISK FACTOR COUNSELING |
| 1. **Screening results given to client verbally and in writing and risk reduction counseling provided**

[ ]  Yes [ ]  No If client is a current smoker – is she ready to quit? [ ]  Yes [ ]  No ASCVD Score       |
| SECTION 6 – FOLLOW-UP |
| 1. **Recommendations. Check all that apply.**
 |
| **Referred for diagnostic office visit (DOV) for ALERT results *(required ≤7 calendar days)***[ ]  BP SBP>180 or DSP > 120 **Referred for DOV for following abnormal result(s):**[ ]  BP > 130 Systolic or BP > 80 Diastolic[ ]  Fasting Glucose > 126 mg/dL or Alc >6.5% (to assess for diabetes diagnosis[ ]  LDL > 130 mg/dL[ ]  Triglycerides > 400 mg/dL [ ]  DOV not medically indicated for abnormal result; already being treated[ ]  Linked to a provider for ongoing care | [ ]  Arranged for Medication[ ]  Depression Follow-up[ ]  Hypertension Management[ ]  Social Services and Support, list:     [ ]  Refused DOV and/or Follow-up |
| Provider Name:       |
| Location:       |
| [ ]  Other, specify:       |
| SECTION 7 – HEALTHY BEHAVIOR SUPPORT BI-DIRECTIONAL REFERRAL, DATE:       |
| 1. **Check Lifestyle Program or Health Coaching option selected by client.**
 |
| [ ]  Take Off Pounds Sensibly[ ]  Diabetes Prevention Program[ ]  Health Coaching (PA, Healthy Eating)[ ]  Health Coaching (SMBP)[ ]  Health Coaching Walk with Ease[ ]  WI Quit Line | [ ]  Other Community Linkages (e.g., smoking groups, farmer’s market, exercise classes), list below:      |
| 1. Client is not ready for Healthy Behavior Support option referral; gave permission to follow up in 30 days.

[ ]  Yes [ ]  No |

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| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-01225 (09/2024) | **STATE OF WISCONSIN**Bureau of Community Health PromotionChronic Disease Prevention and Cancer Control Section |
| wisewoman Healthy Behavior Encounter  |
| **SECTION 1 – CLIENT AND PROVIDER INFORMATION** |
| 1. Provider Agency Name | 2. Performing Provider Name |
|       |       |
| 3. Client MED-IT Number | 4. Date of Contact | 5. Date of the IOV |
|       |       |       |
| 6. Client Name (Last, First MI) | 7. Date of Birth |
|       |       |
| 8. Preferred Contact Option(s) (select all that apply) |
| [ ]  Phone | Main Phone Number:       | Alternate Phone Number:       |
| [ ]  Text | Cell Phone Number:       |
| [ ]  Email | Email Address:       |
| Best Time to Contact |
|       |
| **SECTION 2 – INITIAL HEALTHY BEHAVIOR SUPPORT ENCOUNTER Date:**       |
| 9. Client Selected a HBSS: [ ]  Yes – (Name)       [ ]  No – 30 Day Call Back |
| 10. Client Priority Area (select all that apply) |
| [ ]  Healthy Eating[ ]  Physical Activity[ ]  Blood Pressure Control [ ]  Quit Smoking[ ]  Weight Loss |
| 11. Indicate SMART Goal:       |
| 12. Community Referrals (select all that apply) | 13. Social Services and Support Referrals (select all that apply) |
| [ ]  Healthy Eating[ ]  Physical Activity[ ]  Blood Pressure Control[ ]  Quit Smoking[ ]  Weight Loss[ ]  Other(s) – Specify:       | [ ]  Food Security[ ]  Housing[ ]  Transportation[ ]  Childcare[ ]  Home Safety[ ]  Medication Assistance[ ]  Other(s) – Specify:       |
| SECTION 3 – SUBSEQUENT HEALTH COACHING ENCOUNTERS  |
| *Complete if client had general coaching.* **Date:**       |
| 14. Did the client achieve the stated goal(s)? |
| [ ]  Yes – Client Achieved Goal (select all that apply)[ ]  Eating Healthier[ ]  Increased Physical Activity[ ]  Lower/Controlled Blood Pressure[ ]  Stopped Smoking[ ]  Lost Weight | [ ]  No – Barriers/Challenges (select all that apply)[ ]  Time[ ]  Motivation [ ]  Competing Priorities |
| 15. Did the client make progress on the stated goal(s)? |
| [ ]  Yes – Made Progress on Stated Goal(s) (select all that apply)[ ]  Eating Healthier[ ]  Increased Physical Activity[ ]  Lower/Controlled Blood Pressure[ ]  Stopped Smoking[ ]  Lost Weight | [ ]  No – Barriers/Challenges (select all that apply)[ ] Time[ ]  Motivation [ ]  Competing Priorities |
| 16. Were additional Social Services & Support Referrals offered? [ ]  Yes – Specify:       [ ]  No |
| Summary of Session Notes (*education tools provided and next session date/time*)      |
| SECTION 4 – BLOOD PRESSURE SELF-MONITORING HEALTH COACHING |
| *Complete if client had Blood Pressure Self-Monitoring coaching.* **Date:**       |
| 17. Agreed Provider/Client BP Goal:      /      | Calculated Average SMBP Reading:      /      |
| 18. Did the client achieve blood pressure goal? |
| [ ]  Yes (select all that apply)[ ]  Able to Get Medications[ ]  Taking BP Medications Correctly[ ]  Lowered Sodium[ ]  Doing BPSM[ ]  Readings Shared with Provider[ ]  Lost Weight[ ]  Increased Physical Activity[ ]  Stopped Smoking | [ ]  No – Barriers/Challenges (select all that apply)[ ]  Time[ ]  Motivation [ ]  Competing Priorities |
| 19. Did the client make progress on blood pressure goal? |
| [ ]  Yes (select all that apply)[ ]  Able to Get Medications[ ]  Taking BP Medications Correctly[ ]  Lowered Sodium[ ]  Doing BPSM[ ]  Readings Shared with Provider[ ]  Lost Weight[ ]  Increased Physical Activity[ ]  Stopped Smoking | [ ]  No – Barriers/Challenges (select all that apply)[ ] Time[ ]  Motivation [ ]  Competing Priorities |
| 20. Were additional Social Services & Support Referrals offered? [ ]  Yes – Specify:       [ ]  No |
| Summary of Session Notes (*education tools provided and next session date/time*)      |
| SECTION 5 – WALK WITH EASE HEALTH COACHING |
| *Complete if client had Walk with Ease health coaching.* Date:       |
| Target Walking Time Goal:       |
| 21. Did client achieve target walking time goal? |
| [ ] Yes – Number of Minutes:       | [ ]  No – Barriers (select all that apply)[ ]  Time[ ]  Motivation[ ]  Competing Priorities |
| 22. Did client make progress on target walking time goal? |
| [ ] Yes – Number of Minutes:       | [ ]  No – Barriers (select all that apply)[ ]  Time[ ]  Motivation[ ]  Competing Priorities |
| 23. Were additional Social Services & Support Referrals offered? [ ]  Yes – Specify:       [ ]  No |
| Summary of Session Notes *(education tools provided and next session date/time)*      |
| **Note:** Unsuccessful attempt(s) should be recorded in the Med-IT Recall screen. Examples include, no answer, wrong number, number disconnected, and unable to talk. |