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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? | | |  | |  |  | |  |

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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-01220 (03/2019) | | **STATE OF WISCONSIN**  Bureau of Community Health Promotion  Chronic 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?**         cups   1. **Do you eat fish at least two times a week?**   Yes  No   1. **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 half   1. **Do you drink less than 36 ounces (450 calories) of sugar-sweetened beverages weekly?**   Yes  No   1. **Are you currently watching or reducing your sodium or salt intake?**   Yes  No   1. **In the past 7 days, how often did you have a drink containing alcohol?**   Number of days:       None   1. **How many alcoholic drinks, on average, do you consume during a day you drink?**   Number of drinks:       None   1. **How many minutes of physical activity (exercise) do you get in a week?**   Number of Minutes:        None   1. **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 smoked   1. **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 Health  F-01221 (09/2024) | | | | | | **STATE OF WISCONSIN**  Bureau of Community Health Promotion  Chronic 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  Left   1. 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 Glucose 100-125 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 Health  F-01225 (09/2024) | | | **STATE OF WISCONSIN**  Bureau of Community Health Promotion  Chronic 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. | | | | | | |