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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-01219S (09/2024) | | **STATE OF WISCONSIN**  Bureau of Community Health Promotion  Chronic Disease Prevention and Cancer Control Section | | | | | | | | |
| EVALUACIÓN DE HISTORIAL MÉDICO DEl programa WISEWOMANwisewoman health history assessment | | | | | | | | | | |
| SECCIÓN 1: INFORMACIÓN SOBRE EL CLIENTE Y EL PROVEEDOR | | | | | | | | | | |
| 1. Nombre de la agencia proveedora | 2. Escriba el nombre del proveedor ejecutante en letra de molde | | | | | | 3. Fecha de contacto | | | |
|  |  | | | | | |  | | | |
| 4. Nombre del cliente (Apellido, nombre, inicial del segundo nombre) | | | 5. Fecha de nacimiento | | | | 6. Número de identificación del cliente | | | |
|  | | |  | | | |  | | | |
| **SECCIÓN 2: HISTORIAL MÉDICO PERSONAL** | | | Sí | | No | | No sabe o no está seguro | | No corresponde | |
| 1. Indique si ha padecido algunas de las siguientes: | | |
| * 1. Enfermedad coronaria | | |  | |  | |  | |  | |
| * 1. Ataque al corazón | | |  | |  | |  | |  | |
| * 1. Insuficiencia cardíaca | | |  | |  | |  | |  | |
| * 1. Enfermedad vascular (enfermedad arterial periférica) | | |  | |  | |  | |  | |
| * 1. Derrame cerebral o ataque isquémico transitorio (AIT) | | |  | |  | |  | |  | |
| * 1. Cardiopatías congénitas y defectos | | |  | |  | |  | |  | |
| 1. ¿Toma aspirina todos los días para ayudar a prevenir un ataque al corazón o derrame cerebral? | | |  | |  | |  | |  | |
| 1. ¿Ha padecido hipertensión gestacional? | | |  | |  | |  | |  | |
| 1. ¿Ha padecido diabetes gestacional? | | |  | |  | |  | |  | |
| 1. ¿Ha padecido preeclampsia o eclampsia? | | |  | |  | |  | |  | |
| 1. ¿Tiene el colesterol alto? | | |  | |  | |  | |  | |
| 1. ¿Le recetaron medicamentos **(estatinas)** para bajar su colesterol? | | |  | |  | |  | |  | |
| 1. **¿Le recetaron medicamentos (que no sean estatinas) para reducir el colesterol?** | | |  | |  | |  | |  | |
| 1. Durante los últimos siete días, ¿cuántos días tomó los medicamentos recetados para reducir su colesterol?   Cantidad de días | | | | | | | | |  | |
| 1. ¿Sufre de diabetes (ya sea tipo 1 o tipo 2)? | | |  | |  | |  | |  | |
| 1. ¿Le recetaron medicamentos para bajar el azúcar en la sangre (para la diabetes)? | | |  | |  | |  | |  | |
| 1. Durante los últimos siete días, ¿cuántos días tomó los medicamentos recetados para disminuir el azúcar en la sangre (para la diabetes)? Cantidad de días: | | | | | | | | |  | |
| 1. ¿Sufre de hipertensión (presión arterial alta)? | | |  | |  | |  | |  | |
| 1. ¿Le recetaron medicamentos para bajar su presión arterial? | | |  | |  | |  | |  | |
| 1. Durante los últimos siete días, ¿por cuántos días tomó medicación recetada (incluidos diuréticos o píldoras de agua) para bajar la tensión arterial? Número de días: | | | | | | | | | | |
| 1. ¿Mide su presión arterial en casa o utiliza otras fuentes calibradas en la comunidad (por ejemplo, una farmacia o una clínica gratuita para tomar la presión arterial)?   Sí  No  **Si responde no, marque todas las opciones que correspondan:**  Nunca me dijeron que midiera mi presión arterial  No sé cómo medir la presión arterial  No tengo equipo para medir la presión arterial  No corresponde | | | | | | | | | | |
| 1. ¿Con qué frecuencia mide su presión arterial en casa o utiliza otras fuentes calibradas por la comunidad?   Varias veces al día  Diariamente  Unas pocas veces a la semana  Semanalmente  Mensualmente  Nunca  No corresponde | | | | | | | | | | |
| 1. ¿Comparte regularmente las lecturas de su presión arterial con un proveedor de atención médica para que le dé su opinión? | | | |  | |  | |  | |  |

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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-01220S (03/2019) | | **STATE OF WISCONSIN**  Bureau of Community Health Promotion  Chronic Disease Prevention and Cancer Control Section | | |
| Evaluación de estilo de vida salUDABLE de wisewomanwisewoman healthy lifestyle assessment | | | | |
| **SECCIÓN 1 – INFORMACIÓN DEL CLIENTE Y PROVEEDOR** | | | | |
| 1. Nombre de la agencia proveedora | 2. Escriba en letra de molde el nombre del proveedor actuante | | | 3. Fecha de la visita integrada al consultorio |
|  |  | | |  |
| 4. Nombre del cliente (Apellido, nombre, inicial) | | | 5. Fecha de nacimiento | 6. Número de identificación del cliente |
|  | | |  |  |
| SECCIÓN 2 – EVALUACIÓN DE ESTILO DE VIDA SALUDABLE | | | | |
| 1. **¿Cuántas tazas de frutas y verduras come en un día normal?**         tazas   1. **¿Come pescado al menos dos veces a la semana?**   Sí  No   1. **Cuando se trata de todas las porciones de productos de granos que come en un día típico, ¿cuántos son granos integrales?**   Menos de la mitad Cerca de la mitad Más de la mitad   1. **¿Bebe menos de 36 onzas (450 calorías) de bebidas azucaradas por semana?**   Sí  No   1. **¿Está actualmente controlando o reduciendo su consumo de sodio o sal?**   Sí  No   1. **En los últimos 7 días, ¿con qué frecuencia tomó una bebida que contenía alcohol?**   Número de días:       Ninguno   1. **¿Cuántas bebidas alcohólicas consume, en promedio, durante el día que toma?**   Número de bebidas:       Ninguna   1. **¿Cuántos minutos de actividad física (ejercicio) realiza en una semana?**   Número de minutos:        Ninguno   1. **¿Usted fuma?**   Incluye cigarrillos, pipas o cigarros (tabaco ahumado en cualquier forma)  Fumador actual  Dejó de fumar hace 1 a 12 meses  Dejó de fumar hace más de 12 meses  Nunca fumó   1. **Durante las últimas 2 semanas, ¿con qué frecuencia le ha molestado alguno de los siguientes?**    1. Ha sentido poco interés o placer en hacer las cosas:   En absoluto  Varios días  Más de la mitad del tiempo  Casi todos los días   * 1. Se ha sentido bajo de ánimo, deprimido o sin esperanza:   En absoluto  Varios días  Más de la mitad del tiempo  Casi todos los días | | | | |

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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. | | | | | | |