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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-01219S (11/2019) | **STATE OF WISCONSIN**  Bureau of Community Health Promotion  Chronic Disease Prevention and Cancer Control Section | | | | | | | | | |
| EVALUACIÓN DEL HISTORIAL MÉDICO DE WISEWOMANwisewoman health history 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 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 aplica | |
| 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 / 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. ¿Sufre de 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 medicamentos recetados (incluyendo diuréticos / píldoras de agua) para bajar su presión arterial? Cantidad 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 todo lo que corresponda:**  Nunca me dijeron que midiera mi presión arterial  No sé cómo medir la presión arterial  No tengo equipo para medir la presión arterial  No aplica | | | | | | | | | | |
| 1. ¿Con qué frecuencia mide su presión arterial en casa o utiliza otras fuentes calibradas por la comunidad?   Varias veces al día  Diariamente  Algunas veces por semana  Semanal  Mensual  Nunca  No aplica | | | | | | | | | | |
| 1. ¿Comparte regularmente las lecturas de su presión arterial con un proveedor de atención médica para obtener comentarios? | | | |  | |  | |  | |  |

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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 (03/2020) | **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 | | | | | | | | 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 | | | | | | | Blood Pressure  Cholesterol (Statin)  Cholesterol(Other than Statin)  Blood Sugar  Aspirin (used to prevent heart attack or stroke) | | | | | | |
| 1. Number of minutes/week of physical activity: | | | | | | | 1. Number of cups of fruits/vegetable daily: | | | | | | | | | | |
| 1. Tobacco Use:  Never smoked  Current smoker  Quit smoking | | | | | | | | | | | | | | | | | |
| 1. 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 | | | | | A1c ≥6.5% | | | | | **ALERT ≥250 mg/dL (unless known to have diabetes)** | | |
| 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 | | | | | | | | | | | | | | | | | |
| 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  Glucose >250mg/dl **(unless known to have diabetes)**  Referred for DOV for following **abnormal** result(s):  BP > 130 Systolic or DBP > 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: 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  SNAP-Ed  Health Coaching (PA, Healthy Eating)  Health Coaching (SMBP)  Health Coaching (Diabetes Management)  WI Quit Line | | | | | | | Uncontrolled HTN  ¡Venga y Relajese!  YMCA Blood Pressure Management  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 (03/2019) | **STATE OF WISCONSIN**  Bureau of Community Health Promotion  Chronic Disease Prevention and Cancer Control Section |
| wisewoman healthly behavior encounter | |
| **SECTION 1: CLIENT AND PROVIDER INFORMATION** (Print all information clearly) | |

| Provider Agency Name | | | | | | | Performing Provider Name | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | |  | | | |
| Client ID Number | | | | Date of Contact | | | | | Date of the IOV | |
|  | | | |  | | | | |  | |
| Client Name (Last, First MI) | | | | | | | Date of Birth | | | |
|  | | | | | | |  | | | |
| Preferred Contact Option(s) (check all that apply) | | | | | | | | | | |
| Phone: | Main Phone Number | | | | | | | Alternate Phone Number | | |
|  | | | | | | |  | | |
| Text: | Cell Phone Number | | | | Email: | | | Email Address | | |
|  | | | |  | | |
| Best Time to Contact | | | | | | | | | | |
|  | | | | | | | | | | |
| SECTION 2: CLIENT ACTION PLAN | | | | | | | | | | |
| Client’s SMART Goal | | | | | | | | | | |
|  | | | | | | | | | | |
| Number of Coaching Sessions Completed | | | | | | | | | | |
|  | | | | | | | | | | |
| Which community resources was the client able to use?  Healthy Eating  PA  Quit Smoking Class  Quit Line  Fax to Quit  Free BP Check  Other, specify: | | | | | | | | | | |
| Complete if client had SMBP or Uncontrolled BP Health Coaching   1. Is the client taking her BP meds correctly  Yes  No 2. Is client lowering her sodium intake  Yes  No 3. Is client doing SMBP  Yes  No | | | | | | | | | | |
| SMBP Readings: | | | | | | | | | | |
| Date:       My Blood Pressure:      / | | | | | | | Date:       My Blood Pressure:      / | | | |
| Date:       My Blood Pressure:      / | | | | | | | Date:       My Blood Pressure:      / | | | |
| Date:       My Blood Pressure:      / | | | | | | | Date:       My Blood Pressure:      / | | | |
| Date:       My Blood Pressure:      / | | | | | | | Date:       My Blood Pressure:      / | | | |
| Date:       My Blood Pressure:      / | | | | | | | Date:       My Blood Pressure:      / | | | |
| Notes: | | | | | | | | | | |
|  | | | | | | | | | | |
| SECTION 3: HEALTHLY BEHAVIOR ENCOUNTERS | | | | | | | | | | |
| **IOV Encounter 1 (a) Date:** | | |  | | | **Encounter 2 (a) Date:** | | | |  |
| Did client select HSBI?  Yes  HC  LSP Name  No Call Back in 30 Days | | | | | | Notes about session (progress, barriers, successes educational tools provided) and Next Session Date / Time | | | | |
| Notes about session (progress, barriers, successes educational tools provided) and Next Session Date / Time | | | | | |  | | | | |
|  | | | | | |
| **Encounter 3 (a) Date:** | |  | | | | **Encounter 4 (a) Date:** | | | |  |
| Notes about session (progress, barriers, successes educational tools provided) and Next Session Date / Time | | | | | | Notes about session (progress, barriers, successes educational tools provided) and Next Session Date / Time | | | | |
|  | | | | | |  | | | | |
| **Encounter 5 (a) Date:** | |  | | | | **Encounter 6 (a) Date:** | | | |  |
| Notes about session (progress, barriers, successes educational tools provided) and Next Session Date / Time | | | | | | Notes about session (progress, barriers, successes educational tools provided) and Next Session Date / Time | | | | |
|  | | | | | |  | | | | |
| SECTION 4: ATTEMPTS TO CONTACT CLIENT | | | | | | | | | | |
| Date and Time of Attempt 1 | | | | | | No Answer  Left Message  Unable to Talk  Number Disconnected  Wrong Number | | | | |
| am  pm | | | | | |
| Date and Time of Attempt 2 | | | | | | No Answer  Left Message  Unable to Talk  Number Disconnected  Wrong Number | | | | |
| am  pm | | | | | |
| Date and Time of Attempt 3  Client lost to FU | | | | | | No Answer  Left Message  Unable to Talk  Number Disconnected  Wrong Number | | | | |
| am  pm | | | | | |