

WEST VIRGINIA WISEWOMAN Health History Form

This form is to be filled out by the provider or health coach, NOT the participant

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|--|--|---|---|------|----------------------|
| Provider Name | | Date | | SSN# | |
| Last Name | | First Name | | M.I. | Date of Birth / / |
| HEALTH CONDITIONS | | | | | |
| 1. Which of the following conditions do you have? <input type="checkbox"/> Hypertension <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Diabetes (Type 1 or Type 2) | | | 10. Do you eat fish at least two times a week? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 2. Have you had any of the following? Stroke/TIA <input type="checkbox"/> Yes <input type="checkbox"/> No Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No Coronary Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Failure <input type="checkbox"/> Yes <input type="checkbox"/> No Vascular Disease (peripheral arterial disease) <input type="checkbox"/> Yes <input type="checkbox"/> No | | | 11. Thinking about all the servings of grain products you eat in a typical day, how many are whole grains? <input type="checkbox"/> Less than half <input type="checkbox"/> About half <input type="checkbox"/> More than half | | |
| 3. Have you been prescribed medication to lower? <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Cholesterol (Statin) <input type="checkbox"/> Cholesterol (other prescribed medication) <input type="checkbox"/> Blood Sugar | | | 12. Do you drink less than 36 ounces (450 calories) of sugar sweetened beverages weekly? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 4. Are you taking aspirin daily to help prevent a heart attack or stroke? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | 13. Are you currently watching or reducing your sodium or salt intake? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 5. During the past 7 days, how many days did you take prescribed medication for the following conditions: | | | 14. In the past 7 days, how often do you have a drink containing alcohol? <input type="checkbox"/> Number of days _____ <input type="checkbox"/> None | | |
| I. High Blood Pressure (0-7 days) <input type="checkbox"/> Number of days _____ <input type="checkbox"/> None | II. High Cholesterol (0-7 days) <input type="checkbox"/> Number of days _____ <input type="checkbox"/> None | III. High Blood Sugar (0-7 days) <input type="checkbox"/> Number of days _____ <input type="checkbox"/> None | 15. How many alcoholic drinks, on average, do you consume during a day you drink? <input type="checkbox"/> Number of drinks _____ <input type="checkbox"/> None | | |
| 6. Do you measure your blood pressure at home or using other calibrated sources? <input type="checkbox"/> Yes <input type="checkbox"/> No - was never told to measure my blood pressure <input type="checkbox"/> No - don't know how to measure my blood pressure <input type="checkbox"/> No - don't have the equipment to measure my blood pressure | | | 16. How many minutes of physical activity (exercise) do you get in a week? <input type="checkbox"/> Number of minutes _____ <input type="checkbox"/> None | | |
| 7. How often do you measure your blood pressure at home or using other calibrated sources? <input type="checkbox"/> Multiple times per day <input type="checkbox"/> Daily <input type="checkbox"/> A few times per week <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly | | | SMOKING 17. Do you smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form) <input type="checkbox"/> Current smoker <input type="checkbox"/> Quit (1-12 months ago) <input type="checkbox"/> Quit (more than 12 months ago) <input type="checkbox"/> Never smoked | | |
| 8. Do you regularly share blood pressure readings with a healthcare provider for feedback? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | QUALITY OF LIFE 18. Over the past 2 weeks, how often have you been bothered by any of the following problems: | | |
| | | | I. Little interest or pleasure in doing things? <input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half <input type="checkbox"/> Nearly every day | | |
| | | | II. Feeling down, depressed, or hopeless? <input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half <input type="checkbox"/> Nearly every day | | |
| DIET AND PHYSICAL ACTIVITY | | | | | |
| 9. How many cups of fruits and vegetables do you eat in an average day? <input type="checkbox"/> Number of cups _____ <input type="checkbox"/> None | | | Clinician Signature: _____ Date: _____ | | |