



Arkansas WISEWOMAN
Health Assessment Form

Section to be completed by provider			
Patient Information			
Provider: _____	<input type="checkbox"/> Initial Screening	<input type="checkbox"/> Re-Screening	
BreastCare Number: _____	Name: _____	Date: _____	

Section to be completed by patient			
Patient Medical History			
1. Do you have high cholesterol? (If no, go to question 2)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know/Not sure
1a. Do you take medication to lower your cholesterol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know/Not sure
1b. During the past 7 days (including today), on how many days did you take prescribed medication to lower your cholesterol?	___ days	<input type="checkbox"/> None	<input type="checkbox"/> Don't know/Not sure
2. Do you have hypertension (high blood pressure)? (If no, go to question 3.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know/Not sure
2a. Do you take medication to lower your blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know/Not sure
2b. During the past 7 days (including today), on how many days did you take prescribed medication (including diuretics/water pills) to lower your blood pressure?	___ days	<input type="checkbox"/> None	<input type="checkbox"/> Don't know/Not sure
2c. Do you measure your blood pressure at home or using other calibrated sources? Select all that apply.	<input type="checkbox"/> Yes <input type="checkbox"/> No- don't have equipment <input type="checkbox"/> Don't know/Not sure	<input type="checkbox"/> No- was never told <input type="checkbox"/> No-don't know how	
2d. 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"/> A few times per week <input type="checkbox"/> Monthly	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Don't know/Not sure	
2e. Do you regularly share blood pressure readings with a healthcare provider for feedback?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know/Not sure
3. Do you have diabetes? (Type 1 or 2) (If no, go to question 4)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know/Not sure
3a. Do you take medication to lower your blood sugar (for diabetes)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know/Not sure
3b. During the past 7 days (including today), on how many days did you take prescribed medication to lower blood sugar (for diabetes)?	___ days	<input type="checkbox"/> None	<input type="checkbox"/> Don't know/Not sure
4. Have you been diagnosed by a healthcare provider as having any of these conditions: coronary heart disease/chest pain, heart attack, heart failure, stroke/transient ischemic attack (TIA), vascular disease, or congenital heart defects?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know/Not sure

Nutrition			
5. How much fruit do you eat in an average day? Examples of 1 cup: 1 large banana, 1 small wedge of watermelon, 1 medium grapefruit, 1 small apple, 1 medium pear, 8 large strawberries, 2 large plums	___ cups	<input type="checkbox"/> None	
6. How many vegetables do you eat in an average day? Examples of 1 cup: 10 broccoli florets, 1 large ear of corn, 12 baby carrots, 2 large stalks of celery, 1 large sweet potato	___ cups	<input type="checkbox"/> None	
7. Do you eat two servings or more of fish weekly? Examples of a serving: 7oz of canned tuna, 8oz salmon	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8. Do you eat three ounces or more of whole grains daily? Examples of an ounce: ½ cup oatmeal, 1 slice of whole wheat bread, 3 cups of popcorn	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
9. Do you drink less than 36 ounces (450 calories) of beverages with added sugars weekly? Examples: 3 canned or bottled 12 oz. sodas	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
10. Are you currently watching/ reducing your sodium/salt intake?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	



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Physical Activity	
11. How much moderate physical activity do you get in a week? <i>Examples: walking briskly (3 mph or faster), water aerobics, general gardening</i>	___ minutes <input type="checkbox"/> None
12. How much vigorous physical activity do you get in a week? <i>Examples: race walking, jogging, running, bicycling 10 mph or faster, aerobic dancing</i>	___ minutes <input type="checkbox"/> None
Smoking	
13. Do you smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form)	<input type="checkbox"/> Yes <input type="checkbox"/> Never smoked <input type="checkbox"/> Quit (1-12 months ago) <input type="checkbox"/> Quit (More than 12 months ago)
14. About how many hours a day, on average, are you in the same room or vehicle with another person who is smoking?	___ hours <input type="checkbox"/> Less than one <input type="checkbox"/> None
General Health	
15. Thinking about your physical health, which includes physical illness and injury, on how many days during the past 30 days was your physical health not good?	___ days <input type="checkbox"/> Don't know/Not sure
16. Thinking about your mental health, which includes stress, depression, and problems with emotions, on how many days during the past 30 days was your mental health not good?	___ days <input type="checkbox"/> Don't know/Not sure
17. During the past 30 days, on about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?	___ days <input type="checkbox"/> Don't know/Not sure