



Wise Choices Follow-Up/ Outcome Evaluation

Date _____

Last Name	First Name	Middle Initial	MBCIS ID
Email	Telephone	DOB	

Follow-Up Health Intake

Cholesterol

3. Do you take **statins** to lower your cholesterol?
 Yes No Don't know Not applicable
4. Do you take **other medication** to lower your cholesterol?
 Yes No Don't know Not applicable
5. During the past 7 days, on how many days did you take prescribed medication to lower (including diuretics) your cholesterol? _____ days Don't know Not applicable

Blood Pressure

7. Do you take medication to lower your blood pressure?
 Yes No Don't know Not applicable
8. During the past 7 days, on how many days did you take prescribed medication (including diuretics) to lower your blood pressure? _____ days Don't Know Not Applicable

Blood Sugar (Diabetes)

10. Are you taking medication to lower your blood sugar (for diabetes)?
 Yes No Don't know Not applicable
11. During the past 7 days, on how many days did you take prescribed medication to lower your blood sugar (for diabetes)? _____ days Don't know Not applicable

BP Measurement

14. Are you taking aspirin daily to prevent a heart attack or stroke?
 Yes No Don't know Not applicable
18. Do you measure your blood pressure at home or using other calibrated sources (like a machine at a pharmacy)?
 Yes No – I was never told to measure my blood pressure No – I don't know how to measure my blood pressure No – I don't have equipment to measure blood pressure No – I have equipment, but I don't use it I don't have high blood pressure
19. How often do you measure your blood pressure at home or using other calibrated sources?
 Multiple times per day Daily A few times per week Weekly Monthly Don't know Not applicable
20. Do you regularly share blood pressure readings with a health care provider for feedback?
 Yes No Don't know Not Applicable

Lifestyle

21. How many cups of fruits and vegetables do you eat in an average day (round to the nearest whole number)? _____ cups. *Includes fresh, canned or frozen fruits and vegetables.*

Health Coach _____



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22. Do you eat fish at least two times a week?

(Examples: tuna, salmon, perch, walleye that has been baked, broiled, or grilled, and *not fried*)

- Yes No

23. Thinking about all the servings of grain products you eat in a typical day, how many are whole grains?

(Examples: brown rice, whole wheat bread, oatmeal, all bran cereal)

- Less than half About half More than half

24. Do you drink less than 36 ounces (450 calories) of beverages with added sugars weekly?

(Examples: pop or soda, energy drinks, Kool-Aid, flavored coffee) (1 can of pop = 12 ounces)

- Yes No

25. Are you currently watching or reducing your sodium or salt intake?

- Yes No

26. In the past 7 days, how often did you have a drink containing alcohol? _____ days

27. On average, how many alcoholic drinks do you consume during a day you drink? _____ drinks

28. How many minutes of physical activity (exercise) do you get in a week? _____ hours _____ minutes

Smoking Status

29. 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

30. Do you use any of the following? Smokeless tobacco (including chewing tobacco, snuff, dip, snus, and dissolvable tobacco), bidis, hookah, electronic cigarettes.

- Yes Quit (1-12 months ago) Quit (More than 12 months ago) Not using

31. Do you want to quit using tobacco products?

- No I'm thinking about quitting Yes, I want to quit I quit recently I do not use tobacco

Health Status

32. Over the past 2 weeks, how often have you had little interest or pleasure in doing things?

- Not at all Several days More than half Nearly every day

33. Over the past 2 weeks, how often have you been feeling down, depressed, or hopeless?

- Not at all Several days More than half Nearly every day

WISEWOMAN Follow-Up Screening Form

Screening Date* _____



Wise Choices
Screening Site*

Clinical Measurement	Result	Categories and Protocols for Medical Referral	
Height (inches)		BMI _____ <input type="checkbox"/> Obese: BMI ≥ 30 Consider as risk factor for CVD. No referral for Medical Evaluation <input type="checkbox"/> Overweight: BMI 25.0-29.9 No referral for Medical Evaluation <input type="checkbox"/> Normal: BMI 18.5-24.9 No referral for Medical Evaluation <input type="checkbox"/> Underweight: BMI < 18.5 No referral for Medical Evaluation	
Weight (pounds)*			
<i>(Optional)</i> Waist Circumference (inches)		<input type="checkbox"/> Low to moderate risk: ≤ 35 inches No referral for Medical Evaluation <input type="checkbox"/> High risk: > 35 inches Consider as risk factor for CVD. No referral for Medical Evaluation	<input type="checkbox"/> Unable to obtain <input type="checkbox"/> Client Refused <input type="checkbox"/> Measurement not performed
1 st Blood Pressure (BP)*	/	<input type="checkbox"/> Alert: > 180 (systolic) and/or > 110 (diastolic) (AVCM**) Refer for Medical Evaluation immediately or within 1 week depending on clinical situation and complications <input type="checkbox"/> Stage 2 Hypertension: 160-180 (systolic) and/or 100-110 (diastolic) Refer for Medical Evaluation and Blood Pressure Control Support <input type="checkbox"/> Stage 1 Hypertension: 140-159 (systolic) and/or 90-99 (diastolic) Refer for Medical Evaluation and Blood Pressure Control Support <input type="checkbox"/> Prehypertension: 120-139 (systolic) and/or 80-89 (diastolic) No referral for Medical Evaluation <input type="checkbox"/> Normal: < 120 (systolic) and < 80 (diastolic) No referral for Medical Evaluation	
2 nd BP	/		
Average BP (determine category with this number)	/		
Has Client fasted for at least 9 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Total Cholesterol (mg/dL)		<input type="checkbox"/> High: ≥ 240 mg/dL Refer for Fasting Lipid Profile and Medical Evaluation if not currently being treated for high cholesterol <input type="checkbox"/> Borderline High: 200-239 mg/dL Refer for Fasting Lipid Profile if not currently being treated for high cholesterol (If LDL from fasting lipid profile is ≥ 160 , refer for Medical Evaluation) <input type="checkbox"/> Normal: < 200 mg/dL No referral for Fasting Lipid Profile or Medical Evaluation	
HDL (mg/dL)		<input type="checkbox"/> Undesirable: < 40 mg/dL Fasting Lipid Profile if not currently being treated for high cholesterol (If LDL from fasting lipid profile is ≥ 160 , refer for Medical Evaluation) <input type="checkbox"/> Desirable: 40-59 mg/dL No referral for Medical Evaluation <input type="checkbox"/> Very Desirable: ≥ 60 mg/dL No referral for Medical Evaluation	
LDL Cholesterol (mg/dL)		<input type="checkbox"/> High ≥ 160 Refer for Medical Evaluation <input type="checkbox"/> Borderline High: 130-159 <input type="checkbox"/> Normal: $< 100 - 129$ No referral for Medical Evaluation	
Triglycerides (mg/dL)		<input type="checkbox"/> Very High: ≥ 500 Refer for medical evaluation <input type="checkbox"/> High: 200-499 Refer for medical evaluation <input type="checkbox"/> Borderline: 150 –199 <input type="checkbox"/> Normal: < 150	
Hemoglobin A1c		<input type="checkbox"/> Elevated: $> 7\%$ Refer to provider treating diabetes. If not currently seeing a provider, refer for Medical Evaluation <input type="checkbox"/> Desirable: $\leq 7\%$ No referral for Medical Evaluation	

Signature of Staff Member Conducting Screening _____

WISEWOMAN Follow-Up Screening Form

Screening Date* _____



Fasting Glucose (mg/dL)		<input type="checkbox"/> Alert: ≥ 250 mg/dL Fasting and no history of diabetes (AVCM*) Follow-up Fasting Plasma Glucose and Medical Evaluation within 2 weeks <input type="checkbox"/> Diabetes: 126-249 mg/dL Fasting and no history of diabetes Follow-up Fasting Plasma Glucose and Refer for Medical Evaluation <input type="checkbox"/> Pre-diabetes: 100-125 mg/dL Fasting No referral for Follow-up Fasting Plasma Glucose or Medical Evaluation Refer to Diabetes Prevention Program if no history of diabetes <input type="checkbox"/> Desirable: 70-99 mg/dL Fasting No referral for Follow-up Fasting Plasma Glucose or Medical Evaluation
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*Required field for Follow-Up Screening

**AVCM: Alert Value Case Management

Client referred for Medical Evaluation? Yes No

Client referred for follow-up lab work? Yes No

Risk Reduction Counseling Complete? (Required) Yes No

Alert Value Case Management Required? Yes No

Reason for refused referral _____

Signature of Staff Member Conducting Screening _____



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Lifestyle Program Participation

- On a scale of 0 – 10, how successful were you at meeting your goal?
(0 = not at all successful and 10 = more successful than I ever imagined.) _____
- What helped you be successful or kept you from being successful? _____

- What community resources did you use (if any)? None

<input type="checkbox"/> Walking Club	<input type="checkbox"/> Community Garden
<input type="checkbox"/> SNAP-Ed	<input type="checkbox"/> _____
<input type="checkbox"/> Local Gym	<input type="checkbox"/> _____
<input type="checkbox"/> Farmer's Market	<input type="checkbox"/> _____

- Which lifestyle intervention did you participate in?
 - Health Coaching:** _____ contacts (minimum is 5 sessions)
 - Cooking Matters:** Attended _____ of 6 sessions (4 is complete)
 - DPP:** Attended _____ of 16 core sessions (9 is complete)
 - TOPS:** Participated in _____ weekly meetings (12 is complete)
 - Quitline:** Completed Partially Completed Withdrew when reached Unable to reach

- If you did not complete one of the programs, please explain why.

- For the lifestyle program that you participated in, on a scale of 1 to 10 (with 10 being most satisfied) how satisfied are you with:

The progress you've made toward your goals	1	2	3	4	5	6	7	8	9	10
The quality of the program	1	2	3	4	5	6	7	8	9	10
Your overall experience with the program	1	2	3	4	5	6	7	8	9	10

- What did you find most beneficial about the lifestyle intervention you participated in?

- What would have made your experience better?

- What changes did you make, or have you noticed?

<input type="checkbox"/> I lost weight: _____ pounds	<input type="checkbox"/> None
<input type="checkbox"/> I am eating better: _____	<input type="checkbox"/> My glucose (sugar) is lower
<input type="checkbox"/> I am more physically active: _____ minutes/week	<input type="checkbox"/> Increased confidence
<input type="checkbox"/> I reduced or quit tobacco use (Quit Date: _____)	<input type="checkbox"/> I made new supportive friends
<input type="checkbox"/> I am taking my medication as prescribed	<input type="checkbox"/> I have less stress/anxiety
<input type="checkbox"/> My blood pressure is lower	<input type="checkbox"/> I have more energy
<input type="checkbox"/> Other: _____	<input type="checkbox"/> My mood is better

- Do you feel more confident managing your health now than you did before enrolling in WISEWOMAN?
 Yes No

Health Coach _____