NC WISEWOMAN Screening (DHHS 4049A)

Client Information

Patient Name: *Last* *First* *MI*

Social Security #: _____-_____-_____ **Date of Birth:** _____/_____/_____ **Inactive Date:** _____/_____/_____

Local Patient ID: **Med-IT ID:** **HIS ID (CNDS):**

Address: **Zip Code:**

City: **County:** **State:**

Email: **Preferred Contact:** □ Home (_____)_____-_____ □ Cell (_____)_____-_____ □ Work (_____)_____-_____ **Best time to call:** □ AM □ PM □ N/A

Race/Ethnicity *(select all that apply)*: □ American Indian or Alaska Native □ Asian □ Black or African American □ Hispanic or Latino □ Middle Eastern or North African □ Native Hawaiian Pacific Islander □ White □ Unknown

Primary Language Spoken at Home: □ English □ Spanish □ Arabic □ Chinese □ French □ Italian □ Japanese □ Korean □ Polish □ Russian □ Tagalog □ Vietnamese □ Creole □ Portuguese □ Hmong □ Other Language

Limited English Proficiency? □ Yes □ No

Last Grade Completed: □ <9th grade □ Some high school □ High school grad. or equiv. □ Some college or higher □ Don't know/not sure

Enrollment Status: □ Active □ Inactive □ Moved □ Deceased □ Has Insurance □ Age Ineligible □ Lost to Follow-up □ Income Ineligible

Do you have insurance? □ Yes □ No □ Insufficient □ Unknown **If yes, what type?** □ Medicaid □ Medicare □ Medicare Part A Only □ Private Insurance

Cycle Information

Start Date: _____/_____/_____ **Cycle Type:** □ Baseline □ Reassessment **Enrolling Provider:** _____

WW Patient Navigation Paid By: □ BCCCP □ WISEWOMAN □ Indian Health Services/Tribal Funds □ Other Funds □ N/A (did not receive navigated services)

Office Visit

Visit Type: □ Screening □ Reassessment **Date of Service:** _____/_____/_____ **Provider:** _____

Medical History

a. Have you had any of the following:

I. **Coronary Heart Disease**
□ Yes □ No □ Don't know/not sure

II. **Heart Attack**
□ Yes □ No □ Don't know/not sure

III. **Heart Failure**
□ Yes □ No □ Don't know/not sure

IV. **Vascular Disease (peripheral arterial disease)**
□ Yes □ No □ Don't know/not sure

V. **Stroke/TIA**
□ Yes □ No □ Don't know/not sure

VI. **Congenital Heart Disease and Defects**
□ Yes □ No □ Don't know/not sure

VII. **Gestational hypertension**
□ Yes □ No □ Don't know/not sure

VIII. **Gestational diabetes**
□ Yes □ No □ Don't know/not sure

IX. **Pre-eclampsia/eclampsia**
□ Yes □ No □ Don't know/not sure

b. Are you taking **aspirin daily** to help prevent a heart attack or stroke?
□ Yes □ No □ Don't know/not sure

c. Do you have **high cholesterol**?
□ Yes □ No □ Don't know/not sure

I. Was a statin prescribed to lower your cholesterol?
□ Yes □ No □ Don't know/not sure □ N/A (*if no high cholesterol*)

II. Was a medication other than statin prescribed to lower your cholesterol?
□ Yes □ No □ Don't know/not sure □ N/A (*if no high cholesterol*)

III. During the past 7 days, on how many days did you take prescribed medication to lower your cholesterol?
_____ (number of days) □ None □ N/A (*if no high cholesterol*)

d. Do you have **diabetes** (either Type 1 or Type 2)?
□ Yes □ No □ Don't know/not sure

I. Was a medication prescribed to lower your blood sugar (for diabetes)?
□ Yes □ No □ Don't know/not sure □ N/A (*if no diabetes*)

II. During the past 7 days, on how many days did you take prescribed medication to lower your blood sugar (for diabetes)?
_____ (number of days) □ None □ N/A (*if no diabetes*)

e. Do you have **hypertension** (high blood pressure)?
□ Yes □ No □ Don't know/not sure

III. Was a medication prescribed to lower your blood pressure?
□ Yes □ No □ Don't know/not sure □ N/A (*if no hypertension*)

IV. During the past 7 days, on how many days did you take prescribed medication to lower your blood pressure?
_____ (number of days) □ None □ N/A (*if no hypertension*)

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Client Information **Patient Name:** *Last* *First* *MI*

Blood Pressure, Self Measurement

a. Do you measure your blood pressure at home or using other calibrated sources?
- □ Yes
- □ No-Was never told to measure blood pressure
- □ No-Doesn't know how to measure blood pressure
- □ No-Doesn't have equipment
- □ Don't know/not sure
- □ Not Applicable (*if no hypertension*)

b. 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 sure
- □ Not Applicable (*if no hypertension or not taking at home*)

c. Do you regularly share blood pressure readings with a health care provider for feedback?
- □ Yes
- □ No
- □ Don't know/not sure
- □ Not Applicable (*if no hypertension or not taking at home*)

Nutrition Assessment

a. How many cups of fruits and vegetables do you eat in an average day?
_____ (in cups) □ None

b. Do you eat fish at least two times a week?
□ Yes □ No

c. Thinking about all the servings of grain products you eat in a typical day, how many are whole grains?
□ Less than half □ About half □ More than half

d. Do you drink less than 36 ounces (450 calories) of sugar sweetened beverages weekly?
□ Yes □ No

e. Are you currently watching or reducing your sodium or salt intake?
□ Yes □ No

f. In the past 7 days, how often did you have a drink containing alcohol?
_____ (Number of Days) □ None

g. How many alcoholic drinks, on average, do you consume during a day you drink?
_____ (Number of Drinks) □ None

Physical Activity Assessment

a. How many minutes of physical activity (exercise) do you get in a week? _____ (in minutes) □ None

Smoking Status

a. Do you smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form)
□ Current smoker □ Quit (1-12 months ago) □ Quit(>12 months ago) □ Never Smoked

Quality of Life Assessment

a. 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? □ Not at all □ Several Days □ More than half □ Nearly Every Day
II. Feeling down, depressed, or hopeless? □ Not at all □ Several Days □ More than half □ Nearly Every Day

Clinical Measurements

Height (inches)	Weight (pounds)	Waist circumference (inches)	Blood Pressure (1st Reading)	Blood Pressure (2nd Reading)
			____/____	____/____

Blood Pressure Follow-ups (for women on medication)

Date of follow-up: ____/____/____ **Measurement:** ____/____
Date of follow-up: ____/____/____ **Measurement:** ____/____
Date of follow-up: ____/____/____ **Measurement:** ____/____

Blood Pressure Alert

*(Follow-up **required within 7 days** if Average SBP>180 and/or Average DBP>120)*

Status: □ Medically necessary □Not medically necessary
□Medically necessary follow-up appointment declined
Date of follow-up: ____/____/____ □ N/A

Blood Work

Date of Test: ____/____/____

Fasting: □ Yes (at least 8 hrs; required if history of high cholesterol) □ No

Total Cholesterol	HDL	LDL	Triglycerides	Blood Glucose *(fasting only)*	A1C Percentage *(fasting or non-fasting)*

Medical Evaluation/Case Management *(if medically necessary follow-up completed) □ N/A

Date of ME/CM: ____/____/____

Referred for: □ Alert BP □ Alert Glucose □ Abnormal BP □ Abnormal Glucose/HgA1C □ Abnormal Cholesterol/Triglycerides □ Abnormal BMI

BP Measurement: ____/____ mm Hg

Type of Visit: □ Medical Evaluation

Reason no ME: □ Intends to see provider outside practice □ Refused □ Lost to follow-up □ Appt not available within 7 days

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NC WISEWOMAN Screening (DHHS 4049C) **complete in tandem with DHHS 4050A*

Client Information	**Patient Name:** *Last*	*First*	*MI*
Risk Reduction Counseling	**Counseling Completion Date:** _____/_____/_____	**LSP/HC Referral Date:** □ Refused _____/_____/_____	**Refusal Reason:** □ Not ready to change □ No time □ Other barriers

Priority Areas *(select at least one)*	**Priority?**	**Goal**	**Objective**
a. Nutrition	□ Yes □ No		
b. Physical Activity	□ Yes □ No		
c. Smoking Cessation	□ Yes □ No		
d. Stress Management	□ Yes □ No		
e. Diabetes	□ Yes □ No		
f. Other, _____	□ Yes □ No		

HBSS Barriers

a.	Transportation	□ Was a big problem	□ Was a problem	□ Was not a problem
b.	Financial Issues	□ Was a big problem	□ Was a problem	□ Was not a problem
c.	Family and Social Support	□ Was a big problem	□ Was a problem	□ Was not a problem
d.	Housing Issues	□ Was a big problem	□ Was a problem	□ Was not a problem
e.	Employment Issues	□ Was a big problem	□ Was a problem	□ Was not a problem
f.	Lack of motivation/commitment	□ Was a big problem	□ Was a problem	□ Was not a problem
g.	Education/Health Literacy	□ Was a big problem	□ Was a problem	□ Was not a problem
h.	Unrealistic Goal Setting	□ Was a big problem	□ Was a problem	□ Was not a problem
i.	Lack of Time	□ Was a big problem	□ Was a problem	□ Was not a problem
j.	Other	□ Was a big problem	□ Was a problem	□ Was not a problem

Tobacco Cessation	**Referral Date**	**Completion Status**
□ Quit Line	_____/_____/_____	□ Completed □ Partial □ Withdrawn □ Unable to reach
□ Community-based tobacco program	_____/_____/_____	□ Completed □ Partial □ Withdrawn □ Unable to reach
□ Internet-based tobacco program	_____/_____/_____	□ Completed □ Partial □ Withdrawn □ Unable to reach
□ Other tobacco cessation resources	_____/_____/_____	□ Completed □ Partial □ Withdrawn □ Unable to reach
□ N/A	□ Refused	Refusal Reason: □ Not ready to quit

Community Resource Referral	**Referral Date**	**Referral Outcome**	**Outcome Date**
□ Behavioral Health	_____/_____/_____	□ Complete □ Reschedule □ Scheduled □ Attended □ No Show	_____/_____/_____
□ Diabetes Prevention	_____/_____/_____	□ Complete □ Reschedule □ Scheduled □ Attended □ No Show	_____/_____/_____
□ Housing/Social Support	_____/_____/_____	□ Complete □ Reschedule □ Scheduled □ Attended □ No Show	_____/_____/_____
□ Nutrition	_____/_____/_____	□ Complete □ Reschedule □ Scheduled □ Attended □ No Show	_____/_____/_____
□ Physical Activity	_____/_____/_____	□ Complete □ Reschedule □ Scheduled □ Attended □ No Show	_____/_____/_____
□ Not specified	_____/_____/_____	□ Complete □ Reschedule □ Scheduled □ Attended □ No Show	_____/_____/_____
□ N/A			

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NC WISEWOMAN Screening (DHHS 4049D)

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Social Determinants of Health (SDOH) Assessment

Computer use

During the last 12 months, did you use any of the following?

i. Desktop/Laptop
ii. Smartphone
iii. Tablet/Other portable wireless Computer

□ Yes □ No □ Don't Know

Internet Access

During the last 12 months, did you or any member of this household have access to the internet?

□ Yes, by paying a cell phone company or internet service provider
□ Yes, without paying a cell phone company or internet service provider
□ No access to internet in this house, apartment, or mobile home
□ Don't Know

Food Insecurities

During the last 12 months, was there a time when you were worried you would run out of food because of a lack of money or other resources?

□ Yes □ No □ Don't Know

Transportation Barriers

During the last 12 months, have you missed a doctor's appointment because of transportation problems?

□ Yes □ No □ Don't Know

Childcare *asked as separate questions in Med-IT

If you are currently using childcare services, please identify the type of services you use. (If not using childcare services, please select 'Not applicable'). Select all that apply.

□ Infant (birth to 11 months)
□ Toddler (11 to 36 months)
□ Preschool (3 to 5 years)
□ After School Care (K-9th grade)
□ Not applicable
□ Don't Know

Childcare Barriers *asked as separate questions in Med-IT

During the last 12 months, have you had any of these problems regarding childcare services? (If not using childcare, please select 'Not applicable'.) Select all that apply.

□ Cost
□ Availability
□ Location
□ Transportation
□ Hours of Operation
□ Other
□ Not applicable
□ Don't Know

Housing

What is your housing situation today?

□ I have housing
□ I have housing, but I am worried about losing my housing
□ I do not have housing
□ Don't Know

Safety

Do you feel physically and emotionally safe where you currently live?

□ Yes □ No □ Unsure □DWTA

In the past year, have you been afraid of your partner or ex-partner?

□ Yes □ No □ Unsure □DWTA
□ No partner in the past year

Intimate Partner Violence

How often does your partner physically hurt you, or insult or talk down to you?

□ Never □ Rarely □ Sometimes
□ Fairly Often □ Frequently
□ No partner

Medication Adherence

Regarding your medications, do you ever forget to take it OR are careless at times about taking it OR do you sometimes stop taking it if you feel better or feel worse?

□ Yes □ No

Referrals

Referred To	Date Referred	Outcome	Outcome Date	Comment
□ Computer Use	_____/_____/_____	□ In progress □ Closed □ Refused □ Already receiving service	_____/_____/_____	
□ Internet Access	_____/_____/_____	□ In progress □ Closed □ Refused □ Already receiving service	_____/_____/_____	
□ Food Insecurity	_____/_____/_____	□ In progress □ Closed □ Refused □ Already receiving service	_____/_____/_____	
□ Transportation	_____/_____/_____	□ In progress □ Closed □ Refused □ Already receiving service	_____/_____/_____	
□ Childcare	_____/_____/_____	□ In progress □ Closed □ Refused □ Already receiving service	_____/_____/_____	
□ Housing	_____/_____/_____	□ In progress □ Closed □ Refused □ Already receiving service	_____/_____/_____	
□ Intimate Partner Violence	_____/_____/_____	□ In progress □ Closed □ Refused □ Already receiving service	_____/_____/_____	
□ Medication Adherence	_____/_____/_____	□ In progress □ Closed □ Refused □ Already receiving service	_____/_____/_____	
□ Mental Health	_____/_____/_____	□ In progress □ Closed □ Refused □ Already receiving service	_____/_____/_____	
□ Language Translation	_____/_____/_____	□ In progress □ Closed □ Refused □ Already receiving service	_____/_____/_____	
□ Substance Abuse	_____/_____/_____	□ In progress □ Closed □ Refused □ Already receiving service	_____/_____/_____	
□ Other, _____	_____/_____/_____	□ In progress □ Closed □ Refused □ Already receiving service	_____/_____/_____	

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