# WEST VIRGINIA WISEWOMAN
## Health History

| Provider Name: | Date:_____ | SSN#: _____ |
|---|---|---|

| Last Name: | First Name: | M.I.: _____ | Date of Birth: _____ |
|---|---|---|---|

**Health Conditions**

**1. Which of the following conditions do you have?**

| | | | |
|---|---|---|---|
| **I. Hypertension** | ☐ Yes | ☐ No | ☐ Don't know/Not Sure |
| **II. High Cholesterol** | ☐ Yes | ☐ No | ☐ Don't know/Not Sure |
| **III. Diabetes (type 1 or 2)** | ☐ Yes | ☐ No | ☐ Don't know/Not Sure |

**2. Have you had any of the following? (check all that apply)**

| | | | |
|---|---|---|---|
| Stroke/TIA | ☐ Yes | ☐ No | ☐ Don't Know/Not Sure |
| Heart Attack | ☐ Yes | ☐ No | ☐ Don't Know/Not Sure |
| Coronary Heart Disease | ☐ Yes | ☐ No | ☐ Don't Know/Not Sure |
| Heart Failure | ☐ Yes | ☐ No | ☐ Don't Know/Not Sure |
| Vascular Disease (Peripheral arterial disease) | ☐ Yes | ☐ No | ☐ Don't Know/Not Sure |
| Congenital Heart Disease and Defects | ☐ Yes | ☐ No | ☐ Don't Know/Not Sure |
| Gestational Hypertension | ☐ Yes | ☐ No | ☐ Don't Know/Not Sure |
| Gestational Diabetes | ☐ Yes | ☐ No | ☐ Don't Know/Not Sure |
| Pre-eclampsia/eclampsia | ☐ Yes | ☐ No | ☐ Don't Know/Not Sure |

**3. Was medication prescribed to lower? (check all that apply)**

| | | | |
|---|---|---|---|
| Blood Pressure | ☐ Yes | ☐ No | ☐ Don't Know/Not Sure |
| Cholesterol (Statin) | ☐ Yes | ☐ No | ☐ Don't Know/Not Sure |
| Cholesterol (other prescribed medication) | ☐ Yes | ☐ No | ☐ Don't Know/Not Sure |
| Blood Sugar | ☐ Yes | ☐ No | ☐ Don't Know/Not Sure |

**4. During the past 7 days, how many days did you take prescribed medication for the following conditions:**

**I. High Blood Pressure**
**(0-7 days):** Number of days _____ ☐ None ☐ Don't Know/Not Sure

**II. High Cholesterol**
**(0-7 days):** Number of days _____ ☐ None ☐ Don't Know/Not Sure

**III. High Blood Sugar**
**(0-7 days):** Number of days _____ ☐ None ☐ Don't Know/Not Sure

**5. After being prescribed medication, on what date(s) did you have your blood pressure re-measured either by a healthcare provider or with another community resource?**

_____
_____
_____
_____

**6. Are you taking aspirin daily to prevent a heart attack or stroke?**

☐ Yes ☐ No ☐ Don't Know/Not Sure

**7. Do you measure your blood pressure at home or using other calibrated sources (outside the home)?**

☐ Yes
☐ No-was never told to measure my blood pressure
☐ No-do not know how to monitor my blood pressure
☐ No-do not have the equipment to measure my blood pressure
☐ Don't Know/Not Sure/Other

**8. How often do you measure your blood pressure at home or using other calibrated sources (outside the home)?**

☐ Multiple times per day ☐ Daily
☐ A few times per week ☐ Weekly ☐ Monthly
☐ Don't Know/Not Sure/Other

| | |
|---|---|
| | **9. Do you regularly share blood pressure readings with a health care provider for feedback?** ☐ Yes ☐ No ☐ Don't Know/Not Sure/Other |
| | |
| **Diet and Physical Activity** | |
| **10. How many cups of fruit and vegetables do you eat on an average day?** Number of cups _____ ☐ None | |
| **11. Do you eat fish at least two times a week?** ☐ Yes ☐ No | |
| **12. Thinking about all of the servings of grain products you eat in a typical day, how many are whole grains?** ☐ Less than half ☐ About half ☐ More than half | |
| **13. Do you drink less than 36 ounces (450 calories) of sugar sweetened beverages weekly?** ☐ Yes ☐ No | |
| **14. Are you currently watching or reducing your sodium or salt intake?** ☐ Yes ☐ No | |
| **15. In the past 7 days, how often have you had a drink containing alcohol?** Number of days _____ ☐ None | |
| **16. How many alcoholic drinks, on average, do you consume during a day?** Number of drinks _____ ☐ None | |
| **17. How many minutes of physical activity (exercise) do you get in a week?** Number of minutes _____ ☐ None | |
| **18. 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 | |
| **19. Over the past 2 weeks, how often have you been bothered by any of the following problems?** | |
| **1. 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 |