

# Clinical Measures and Followup Form

**FOR INTERNAL USE ONLY**  
**(For Strategy 3)**

Participant identification (ID) number: \_\_\_\_\_

Name of person completing the form: \_\_\_\_\_

Community health worker's identification (ID) number: \_\_\_\_\_

**Project Location:**

<sub>1</sub> Clinic

**Participant Information**

1. Today's date (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Age \_\_\_\_

3. Gender: <sub>1</sub> Male <sub>2</sub> Female

4. Do you consider yourself Latino or Hispanic? <sub>1</sub> Yes <sub>2</sub> No

5. What race do you consider yourself to be?  
<sub>1</sub> Alaska Native  
<sub>2</sub> American Indian  
<sub>3</sub> Asian  
<sub>4</sub> Black or African American  
<sub>5</sub> Native Hawaiian or other Pacific Islander  
<sub>6</sub> White

6. (a) Place of birth: \_\_\_\_\_  
City State Country

(b) If your place of birth is in the Philippines, the city is located in the:  
<sub>1</sub> Northern Philippines <sub>2</sub> Central Philippines <sub>3</sub> Southern Philippines <sub>4</sub> N/A

7. Time living in the United States: \_\_\_\_ Years \_\_\_\_ Months

8. (a) Language you prefer: <sub>1</sub> English <sub>2</sub> Tagalog <sub>3</sub> Both <sub>3</sub> Other

(b) If language is "Other," please name the language you prefer: \_\_\_\_\_

9. Does your family have a history of heart disease? <sub>1</sub> Yes <sub>2</sub> No <sub>3</sub> Don't know

## Clinical Measures and Followup Form *(continued)*

	<b>Baseline</b> Date: __/__/__	<b>6 Months After Baseline</b> Date: __/__/__	<b>12 Months After Baseline</b> Date: __/__/__
<b>10. Blood cholesterol</b>			
Have you ever been told by a doctor or other health professional that you have high blood cholesterol?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Are you on medication(s)?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Total blood cholesterol	_____ mg/dL	_____ mg/dL	_____ mg/dL
LDL	_____ mg/dL	_____ mg/dL	_____ mg/dL
HDL	_____ mg/dL	_____ mg/dL	_____ mg/dL
Triglycerides	_____ mg/dL	_____ mg/dL	_____ mg/dL
<b>11. Blood pressure</b>			
Have you ever been told by a doctor or other health professional that you have prehypertension?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Have you ever been told by a doctor or other health professional that you have high blood pressure?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Are you on medication(s)?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Average of two readings			
Systolic (top number)	_____ mmHg	_____ mmHg	_____ mmHg
Diastolic (bottom number)	_____ mmHg	_____ mmHg	_____ mmHg

## Clinical Measures and Followup Form *(continued)*

	<b>Baseline</b> Date: __/__/__	<b>6 Months After Baseline</b> Date: __/__/__	<b>12 Months After Baseline</b> Date: __/__/__
<b>12. Diabetes</b>			
Have you ever been told by a doctor or other health professional that you have prediabetes?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Have you ever been told by a doctor or other health professional that you have high blood glucose?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Are you on medication(s)?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Hb A1C	_____ %	_____ %	_____ %
Blood glucose level (fasting)	_____ mg/dL	_____ mg/dL	_____ mg/dL
<b>13. Overweight and obesity</b>			
Weight	_____ pounds or _____ kilograms	_____ pounds or _____ kilograms	_____ pounds or _____ kilograms
Height	___ feet ___ inches or ___ centimeters	___ feet ___ inches or ___ centimeters	___ feet ___ inches or ___ centimeters
Body mass index (BMI)	_____ BMI	_____ BMI	_____ BMI
Waist measure	___ inches or ___ centimeters	___ inches or ___ centimeters	___ inches or ___ centimeters
<b>14. Medication (If the patient is on medication[s], ask the question below.)</b>			
Do you take your medication(s) as prescribed by the doctor?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

## Clinical Measures and Followup Form *(continued)*

<b>15. If the answer to question 14 is “no,” please ask the patient: “Can you tell me why you are not taking your medication?” (Based on the patient’s response, please check all the answers that apply.)</b>			
	<b>Baseline</b> Date: __/__/__	<b>6 Months After Baseline</b> Date: __/__/__	<b>12 Months After Baseline</b> Date: __/__/__
a. I believe that taking medication every day is not good for me.	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
b. I forget to take my medication.	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
c. I did not understand what the doctor told me.	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
d. I stopped taking the medication when I felt better.	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
e. I feel sick when I take the medication.	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
f. I do not have anyone to help me.	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
g. I do not have money to buy the medication(s).	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
h. <b>Other reason (please specify):</b>	_____ _____	_____ _____	_____ _____