

Clinical Measures and Followup Form

FOR INTERNAL USE ONLY
(For Strategy 3)

Participant identification (ID) number: _____

Name of person completing the form: _____

Promotor(a) identification (ID) number: _____

Project Location:

₁ Clinic

Participant Information

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

2. Age (in years): ____

3. Gender: ₁ Male ₂ Female

4. Do you consider yourself Latino or Hispanic? ₁ Yes ₂ No

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

6. Place of birth: _____
City State Country

7. Time living in the United States: ____ Years ____ Months

8. Preferred language: ₁ English ₂ Spanish ₃ Both

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

	Baseline Date: __/__/__	6 Months After Baseline Date: __/__/__	12 Months After Baseline Date: __/__/__
10. Blood cholesterol			
Have you ever been told by a doctor or other health professional that you have high blood cholesterol?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Are you on medication?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No

Clinical Measures and Followup Form *(continued)*

	Baseline Date: ___/___/___	6 Months After Baseline Date: ___/___/___	12 Months After Baseline Date: ___/___/___
Total	_____ 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
11. Blood pressure			
Have you ever been told by a doctor or other health professional that you have prehypertension?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Have you ever been told by a doctor or other health professional that you have high blood pressure?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Are you on medication?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Average of two readings			
Systolic	_____ mmHg	_____ mmHg	_____ mmHg
Diastolic	_____ mmHg	_____ mmHg	_____ mmHg
12. Diabetes			
Have you ever been told by a doctor or other health professional that you have prediabetes?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Have you ever been told by a doctor or other health professional that you have high blood glucose?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Are you on medication?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Hb A1C	_____ %	_____ %	_____ %
Blood glucose level (fasting)	_____ mg/dL	_____ mg/dL	_____ mg/dL

Clinical Measures and Followup Form *(continued)*

	Baseline Date: __/__/__	6 Months After Baseline Date: __/__/__	12 Months After Baseline Date: __/__/__
13. Overweight and obesity			
Weight	_____ pounds or _____ kilograms	_____ pounds or _____ kilograms	_____ pounds or _____ kilograms
Height	___ feet ___ inches or ___ mcters ___ centimeters	___ feet ___ inches or ___ meters ___ centimeters	___ feet ___ inches or ___ meters ___ centimeters
Body mass index (BMI)	_____ BMI	_____ BMI	_____ BMI
Waist measure	___ inches or ___ centimeters	___ inches or ___ centimeters	___ inches or ___ centimeters
14. Medication (If the patient is on medication[s], ask the question below.)			
Do you take your medication as prescribed by the doctor?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
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.)			
	Baseline Date: __/__/__	6 Months After Baseline Date: __/__/__	12 Months After Baseline Date: __/__/__
a. I believe that taking medication every day is not good for me.	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
b. I forget to take my medication.	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
c. I did not understand what the doctor told me.	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
d. I stopped taking the medication when I felt better.	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
e. I feel sick when I take the medication.	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
f. I do not have anyone to help me.	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
g. I do not have money to buy the medication.	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
h. Other reason (please specify):	_____ _____	_____ _____	_____ _____