Client Identification

Program # ___ ___ ___

ID # ___ ___ ___ ___ ___ ___ ___ ___ ___

Last Name _____
Please PRINT

First Name _____
Please PRINT

Middle Initial _____

Height, Weight, Blood Pressure Evaluation (complete at time of second health assessment)

1. Ht, Wt, BP Evaluation Date: ___ ___ / ___ ___ / ___ ___ ___ ___
(mm / dd / yyyy)

2. Height: __ __ inches

3. Weight: __ __ pounds

4. Blood Pressure ***(two readings required):***

4a. 1st Reading: __ __ __ / __ __ __ mmHg

4b. 2nd Reading: __ __ __ / __ __ __ mmHg

Lab Results at Evaluation (*only* complete this section if preauthorized by IDPH)

Blood Lipids:

◯ 5. Lipid Panel Performed *(mark if performed)*

6. Lipids Draw Date: __ __ / __ __ / __ __ __ __
(mm / dd / yyyy)

6a. Total cholesterol: ____ ____ ____ mg/dL

6b. HDL cholesterol: ____ ____ ____ mg/dL

6c. LDL cholesterol: ____ ____ ____ mg/dL

6d. Triglycerides: ____ ____ ____ ____ mg/dL

Blood Glucose (<u>ONLY</u> if fasting):

◯ 7. Glucose Performed *(mark if performed)*

8. Glucose Draw Date: __ __ / __ __ / __ __ __ __
(mm / dd / yyyy)

8a. Glucose reading: ____ ____ ____ mg/dL

HbA1C:

◯ 9. HbA1C Performed *(mark if performed)*

10. HbA1C Draw Date: __ __ / __ __ / __ __ __ __
(mm / dd / yyyy)

10a. HbA1C reading: ____ ____ ____ %

11. Did client fast at least 9 hours prior to having blood drawn for lipids or glucose measurements?

◯ 1. Yes

◯ 2. No

NOTE: For any Lipids reading (6a-6d) not able to be completed, place the following letter in the item's box: ***I*** *= Inadequate blood sample*
If LDL reading (6c) could not be determined, place the following letter in the item's box: ***L*** *= LDL could not be determined*

NOTE: For Glucose reading (8a) not able to be completed, place the following letter in the item's box: ***I*** *= Inadequate blood sample*

NOTE: For HbA1C reading (10a) not able to be completed, place the appropriate letter in the item's box: ***I*** *= Inadequate blood sample*