6478

FAX COMPLETED FORM TO:
1-800-858-6804

CHAP
Cardiovascular Health Awareness Program
Programme de sensibilisation à la santé cardiovasculaire

Risk Profile Recording Form

Kenora

Session Pharmacy ID
29 [ ] : [ ]
(2-digit) (2-letter)

Participant Information - Please PRINT CLEARLY in CAPITALS.

Last Name
First Name
Family MD's Last Name

Sex ○ Male ○ Female
Postal Code (e.g. L5V7Q2)
Date of Birth 1 9 [ ] [ ] - [ ] [ ] [ ] - [ ] [ ]
(year) (3-letter mo.) (day)

Consent to Release Participant Information

Do you consent to having this information sent to your family physician? ○ Yes ○ No

Do you consent to having this information sent to your regular pharmacist? ○ Yes ○ No

Blood Pressure & Pulse Rate (average of 5 readings)

Systolic [ ] [ ] [ ] mm Hg Pulse Rate [ ] [ ] [ ] bpm

Diastolic [ ] [ ] [ ] mm Hg Cuff Size: ○ S ○ M ○ L ○ XL

Cardiovascular Disease & Stroke Risk Profile

For each question, solidly **FILL** one circle like this ● and not like this ⊘ or this ⊘. Thanks!

1. Is this a repeat visit? ○ Yes ○ No

Please complete questions 2 to 20 below if you have not done so in the past year.

2. In general, would you say your health is: ○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent
3. What is your height? [ ] ft [ ] [ ] in OR [ ] [ ] [ ] cm
4. What is your weight? [ ] [ ] [ ] lbs OR [ ] [ ] [ ] kg
5. Have you ever had a transient ischemic attack (TIA or mini-stroke)? ○ Yes ○ No ○ Not sure
6. Have you ever had a stroke? ○ Yes ○ No ○ Not sure
7. Have you ever had a heart attack? ○ Yes ○ No ○ Not sure
8. Has your doctor told you that your cholesterol is high? ○ Yes ○ No ○ Not sure
9. Has your doctor told you that you have diabetes? ○ Yes ○ No ○ Not sure
10. Have you ever been diagnosed with high blood pressure by a doctor? ○ Yes ○ No ○ Not sure
11. Are you currently taking prescription pills for high blood pressure? ○ Yes ○ No ○ Not sure
12. If you currently use pills for high blood pressure, do you take them each day? ○ Yes ○ No ○ Not applicable
13. Do you currently smoke? ○ Yes ○ No
14. In a typical week, how many times do you eat high fat or fast foods? ○ Zero ○ 1-2 ○ 3 or more
15. Typically, do you drink 2 or more alcoholic drinks a day? ○ Yes ○ No
16. Do you eat 5 servings or more of fruits and vegetables a day? ○ Yes ○ No
17. How frequently do you add salt to foods during cooking or at the table? ○ Rarely ○ Sometimes ○ Often
18. In a typical week, how frequently do you feel overwhelmed or stressed? ○ Rarely ○ Sometimes ○ Often
19. Are you moderately physically active for 30 to 60 minutes, most days of the week? (e.g. brisk walking, active gardening, swimming, dancing or biking).. ○ Yes ○ No
20. Do you live alone? ○ Yes ○ No

Office Use Only (Print in CAPS)

Today's Date 2 0 1 0 - [ ] [ ] [ ] - [ ] [ ]
(year) (3-letter mo.) (day)

Pt's Birthdate 1 9 [ ] [ ] - [ ] [ ] [ ] - [ ] [ ]
(year) (3-letter mo.) (day)

Family MD's ID [ ] [ ] [ ] : [ ] [ ] [ ]
(3-letter) (3-digit)

Regular Pharmacy's ID [ ] [ ] : [ ] [ ]
(2-digit) (2-letter)

First 4 **letters** of Pt's Last Name [ ] [ ] [ ] [ ]

Office Use Only (Solidly **FILL** squares like this ■, not like this ☒)

Recommendations (Fill ALL that apply)

- ☐ Attend another CHAP+AP session for reassessment
- ☐ Make appointment with family physician
- ☐ See regular pharmacist

OR ☐ None of the above Recommendations

Actions (Fill ALL that apply)

- ☐ Nurse alerted for assessment and follow-up
- ☐ Session pharmacist alerted

OR ☐ None of the above Actions

Session Pharmacy ID? At top AND bottom pls.

Session Pharmacy ID
(2-digit) (2-letter)
29 [ ] : [ ]

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