



Check _____

Cash _____

CLIENT DATA FORM

How many hours did you fast? _____

Have we tested you before? Y N

SEX: Female Male

BIRTH DATE: ____ -- ____
month day year

NAME (Print) _____
LAST name FIRST name

ADDRESS (number/street) _____

CITY _____ STATE _____ ZIP _____ PHONE _____

YOUR AGE _____ YOUR HEIGHT _____ YOUR WEIGHT _____

CURRENT HISTORY	Circle one
Do you have a medical provider?	Y N
Are you currently using tobacco?	Y N
Have you quit tobacco use recently? How long ago? _____ months _____ years	Y N
Do you currently do some form of physical activity on a regular basis? (at least 3 times/week)	Y N

DIABETES	
Does a parent, grandparent, brother, or sister have diabetes? <input checked="" type="checkbox"/> Check box if unknown <input type="checkbox"/>	Y N
Do you have diabetes? If yes, do you control diabetes by: Medicine: Y N Diet: Y N Exercise: Y N	Y N

HEART HEALTH	
Do you take a prescribed cholesterol-lowering medication?	Y N
Do you have a history of high blood pressure?	Y N
Do you take a prescribed blood pressure medication?	Y N
Are you taking herbal or over the counter products for cholesterol or blood pressure?	Y N

CONSENT FOR BLOOD SAMPLE:

I consent to having a blood sample drawn for the purpose to determine my blood cholesterol level. The screening will be kept confidential. UNDER 18 a parent signature is required

Signature

Parent/Guardian

Today's Date

THIS FORM ALSO AVAILABLE ON CDHD WEB SITE:
www.cdhd.idaho.gov

April 2011

WC

/_____
BP Reading