

Consent for Cardiovascular Risk Factor Screening:

Florida Heart Research Institute, an independent, nonprofit 501(c)(3) organization, is providing this free cardiovascular risk factor screening. If you choose to participate in this screening:

- Your blood pressure and body mass index will be measured.
- Your cholesterol and glucose will be measured. This will require that a few drops of blood be drawn from your finger. It is very safe but like any test in which blood is taken there is always a small amount of risk including infection. You need to understand and accept this risk if you want to participate in this screening.
- You will also be offered free educational material related to cardiovascular risk factors and heart disease prevention.
- You agree to allow Florida Heart Research Institute to contact you for periodic follow up information.
- If any of your results constitute a life threatening emergency, 9-1-1 will be called.

A copy of your blood pressure, cholesterol, and glucose results will be provided to you. You are responsible for sharing these results with your healthcare provider. This service is provided for your education and information only. FHRI does not provide medical care or treatment.

If follow up medical treatment is recommended due to screening results that are outside the normal limits, and you don't have a personal physician, you will be given a referral to a Federally Qualified Healthcare Clinic that provides treatment on a sliding fee scale based on ability to pay. Only summary statistics derived from this screening will be shared for educational and public health purposes. All identifying material will be kept completely confidential.

Consent Statement: I am voluntarily participating in The Cardiovascular Risk Factor Screening. I acknowledge that I have chosen to engage in this event with its inherent risks and accept the liability for such risks attendant to this activity. I also agree to allow Florida Heart Research Institute to contact me for periodic follow up information should my results fall outside of normal ranges.

Signature: _____ **Date:** _____

Please Print:

_____	_____	____/____/____	
First Name	Last Name	Date of Birth	
_____	_____	_____	_____
Address	City	State	Zip
_____	_____	Best time to call	<input type="radio"/> Morning
Day Phone	Evening Phone		<input type="radio"/> Afternoon
			<input type="radio"/> Evening
			<input type="radio"/> Anytime

Additional Contact Information (close friend or relative):

_____	_____	_____	_____
First Name	Last Name	Telephone	Relationship

The following pages contain Survey questions.

PLEASE COMPLETELY FILL IN the bubble that corresponds to your answer.

Examples:

- | | | | |
|-------------------|----------------------------------|-----------------------|-----------------------|
| Correct | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Incomplete | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Incorrect | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

For office use only

1. Your Birth Date: ____/____/____

2. Gender: M F → If Female, are you pregnant? Y N

3. Ethnicity:

- 1 Non-Hispanic
- 2 Hispanic
- 3 Haitian
- 4 Caribbean
- 5 Other _____

4. Race:

- 1 Black
- 2 White
- 3 American Indian
- 4 Pacific Islander
- 5 Indian
- 6 Asian
- 7 Other _____

5. Insurance:

- 1 No insurance
- 2 Private health insurance
- 3 Medicare / Medicaid
- 4 Other _____

6. Where do you go most often for health care? Please choose one:

- 1 Doctor's office
- 2 Clinic
- 3 Emergency room
- 4 Out of the country
- 5 Don't go for health care
- 6 Other _____

7. When was your last physical examination?

- 1 Less than 1 year ago
- 2 1 year ago
- 3 2 years ago
- 4 3 – 4 years ago
- 5 More than 4 years ago
- 6 Other _____

8. Does anyone in your immediate family have a history of heart disease?

- Y Yes
- N No
- ? I don't know

Continued on Back →



9. When did you last have your cholesterol, blood sugar and blood pressure checked?

- ① Less than 1 year ago
- ② 1 year ago
- ③ 2 years ago
- ④ 3 – 4 years ago
- ⑤ More than 4 years ago
- ⑥ Other _____

10. Do you smoke (any tobacco product)? Y N
If Yes, how many?

- ① 1 - 5 per day
- ② 6 - 10 per day
- ③ 11 - 20 per day
- ④ More than 20 per day

11. Has any medical professional ever told you that you have:

- High blood sugar (**diabetes**)? Y N
- High blood pressure (**hypertension**)? Y N
- High **cholesterol**? Y N
- Coronary heart disease?** (Coronary bypass surgery, stent, angioplasty, heart attack) Y N

12. Have you been prescribed medication?

			<u>Always or Almost Always</u>	<u>About 75% of the Time</u>	<u>About 50% of the Time</u>	<u>About 25% of the Time</u>	<u>Never or Almost Never</u>
For high blood sugar (diabetes)?	<input type="radio"/> Y <input type="radio"/> N	If Yes, do you take this medication?	①	②	③	④	⑤
For high blood pressure (hypertension)?	<input type="radio"/> Y <input type="radio"/> N	If Yes, do you take this medication?	①	②	③	④	⑤
For high cholesterol ?	<input type="radio"/> Y <input type="radio"/> N	If Yes, do you take this medication?	①	②	③	④	⑤
For coronary heart disease ?	<input type="radio"/> Y <input type="radio"/> N	If Yes, do you take this medication?	①	②	③	④	⑤

13. In the last month, how often were you physically active? (Physical activity includes at least 30 minutes of fitness walking, cycling, jogging, swimming, aerobic dance or active sports.)

- ① 7 days a week
- ② 5 - 6 days a week
- ③ 3 - 4 days a week
- ④ 1 – 2 days a week
- ⑤ 1 – 3 times a month
- ⑥ Never or almost never

14. Which one of the following best describes your fat intake in the last month?

High fat examples: hamburgers, hot dogs, bologna, steaks, sour cream, cheese, whole milk, eggs, butter, cake, pastry, ice cream, chocolate, fried foods, and many fast foods.

Low fat examples: lean meats, skinless poultry, fish, skim milk, low fat dairy products, fruit desserts, gelatin, vegetables, pasta, legumes (peas & beans).

- ① Primarily low fat foods
- ② Mostly low fat, some high fat
- ③ Both high fat & low fat about the same
- ④ Mostly high fat, some low fat
- ⑤ Primarily high fat foods

15. Which of the following best describes the kind of breads & grains you've eaten in the last month?

Refined grain examples: white bread, rolls, regular pancakes and waffles, white rice, typical breakfast cereals, typical baked goods

Whole grain examples: whole grain breads, brown rice, oatmeal, whole grain or high fiber cereals

- ① Primarily whole grain products
- ② Mostly whole grain, some refined
- ③ Both about the same
- ④ Mostly refined, some whole grain
- ⑤ Primarily refined grain products

16. On a typical day for this past month, how many servings of fruits & vegetables did you eat?

A serving is: 1 cup fresh, ½ cup cooked, 1 medium size fruit, or ¾ cup juice

- ① 5 or more a day
- ② 4 a day
- ③ 3 a day
- ④ 2 a day
- ⑤ 1 or less a day

17. In the last month, how often have you eaten food from fast food restaurants (McDonalds, Burger King, etc.)?

- ① Never or almost never
- ② 1-3 times per month
- ③ 1-2 times per week
- ④ 3-4 times per week
- ⑤ 5-6 times per week
- ⑥ Everyday

18. If you ate fast food in the last month (#17), what type was it?

High fat examples: fried food, breaded items, taco salads, nachos, double burgers, pizza, hot dogs, croissant items, donuts, shakes, cakes

Low fat examples: salads (no creamy dressings), single burgers, grilled chicken, fruits and yogurt parfaits

- ① Primarily low fat foods
- ② Mostly low fat, some high fat
- ③ Both high fat & low fat about the same
- ④ Mostly high fat, some low fat
- ⑤ Primarily high fat foods

The End



Thank you for completing this form!



STAFF USE ONLY

Complete all information below and make sure all results have been copied to results form in front of participant.

For results NOT within normal limits,
did they learn this for the first time today?

02/10/10

Blood Pressure: Systolic _____ Diastolic _____ (Y) (N)
Height: _____ in. Weight: _____ lbs. BMI: _____ (Y) (N)
Total Cholesterol _____ (Y) (N)
Glucose _____ (Y) (N)
HDL _____ (Y) (N)
TC/HDL _____ (Y) (N)

Call 9-1-1 if BP \geq 160 / 100 with symptoms of chest pain, shortness of breath, dizziness, headache, or blurred vision or if BP \geq 200 / 110 without symptoms*

* I'm aware of my high blood pressure numbers, however I refuse to have 911 called at this time. I am responsible to follow up with my personal physician as soon as possible.

Signature _____

Refer to physician if : BP \geq 140 systolic; \geq 90 diastolic; TC \geq 240, TC / HDL ratio \geq 4.1, or Glucose \geq 200

REFERRED TO:

Notes: _____

- ① Personal Physician
- ② Jessie Trice Community Health Center
- ③ Miami Beach Community Health Center
- ④ Open Door Health Center
- ⑤ ER (911 called)
- ⑥ Other _____

Screener Statement:

- ① This participant was found to have at least 1 **At-Risk** value (Systolic BP \geq 140, Diastolic BP \geq 90, TC \geq 240, TC/HDL ratio \geq 4.1, or Glucose \geq 200) and **was REFERRED** for medical care.
- ② This participant did not receive a referral because all values were less than indicated above.

Initials: _____

Event ID: _____



English

Pt Id # _____