



WESTPORT WESTON HEALTH DISTRICT

180 Bayberry Lane, Westport, CT 06880-2855

Telephone: (203) 227-9571

CHOLESTEROL SCREENING REGISTRATION FORM

Please Print:

Name: _____

Daytime Telephone: _____

Address: _____

Date of Birth: _____

Town: _____ State: _____ Zip Code: _____ Male Female

Do you have a history of heart disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had your cholesterol checked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have hypertension?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fasting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	List your Medications:	_____
Do you have a family history of diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Do you have a family history of heart disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you more than 30% overweight?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you exercise regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Physician: _____

Address: _____ Town: _____ State: _____ Zip: _____

CONSENT AND RELEASE FOR CHOLESTEROL SCREENING:

I hereby consent to the drawing and testing of a blood sample for screening purposes. I hereby release the Westport Weston Health District from any and all liability arising from or in any way connected with this procedure. I understand that this is a screening test and that any information received does not constitute a diagnosis of any kind. I also understand that the responsibility for initiating a follow-up examination to confirm the results and obtain advise and treatment is mine and not that of the organization associated with this screening.

Signature: _____ Date: _____

Screeener: _____ Date: _____ Screening site: _____

SCREENING RESULTS

BP _____	TRG _____ mg/dl	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Personal History	<input type="checkbox"/> Family History
TC _____ mg/dl	BS _____ mg/dl	<input type="checkbox"/> Low HDL	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Smoking
HDL _____ mg/dl		<input type="checkbox"/> High TRG	<input type="checkbox"/> Overweight	<input type="checkbox"/> Lack of exercise
LDL _____				
Ratio _____				

Recommendation:	<input type="checkbox"/> Referral for medical evaluation	<input type="checkbox"/> Nutritional evaluation
	<input type="checkbox"/> Re-screen on different day (BS)	<input type="checkbox"/> Exercise
	<input type="checkbox"/> Re-screen in 2-3 months	<input type="checkbox"/> Smoking Cessation
	<input type="checkbox"/> Re-screen in 1-2 years	<input type="checkbox"/> Stress management