WESTPORT WESTON HEALTH DISTRICT
180 Bayberry Lane, Westport, CT 06880-2855
Telephone: (203) 227-9571 Telefax (203) 221-7199

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?	☐ Yes ☐ No	When was your cholesterol last checked?	_____
Do you have hypertension?	☐ Yes ☐ No	Have you fasted today?	☐ Yes ☐ No
Do you have diabetes?	☐ Yes ☐ No	List your Medications:	
Do you have a family history of diabetes?	☐ Yes ☐ No	_____	
Do you have a family history of heart disease?	☐ Yes ☐ No	_____	
Do you smoke?	☐ Yes ☐ No		
Are you more than 30% overweight?	☐ Yes ☐ No		
Do you exercise regularly?	☐ Yes ☐ 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: _____

Screener: _____ Date: _____Screening site:_____

SCREENING RESULTS

BP _____		☐ Hypertension	☐ Personal History	☐ Family History
TC _____mg/dl	TRG _____mg/dl	☐ Low HDL	☐ Diabetes	☐ Smoking
HDL _____mg/dl	BS _____ mg/dl	☐ High TRG	☐ Overweight	☐ Lack of exercise
LDL _____				
Ratio _____				

Recommendation:	☐ Referral for medical evaluation	☐ Nutritional evaluation
	☐ Re-screen on different day (BS)	☐ Exercise
	☐ Re-screen in 2-3 months	☐ Smoking Cessation
	☐ Re-screen in 1-2 years	☐ Stress management