

McLAREN  
**HEART HEALTH and STROKE SCREENING  
CONSENT/RISK ASSESSMENT FORM**

Name: \_\_\_\_\_  Male  Female  
Race/Ethnicity: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Age: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Name and Address of Your Primary Care Physician:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**Do You Want McLaren to Send Your Screening Results to Your Physician?**  Yes  No

Would you like to receive future health screening & program announcements?  Yes  No  Already receive

How did you learn about this screening? \_\_\_\_\_

**Medical History. Please circle either "yes" or "no" for each:**

Do you have a previous history of any of the following medical conditions?

- |                               |     |    |                        |     |    |
|-------------------------------|-----|----|------------------------|-----|----|
| 1. Previous Stroke            | Yes | No | 6. Atrial Fibrillation | Yes | No |
| 2. Previous Mini-Stroke (TIA) | Yes | No | 7. Heart Surgery       | Yes | No |
| 3. Previous Heart Attack      | Yes | No | 8. High Blood Pressure | Yes | No |
| 4. Heart Disease              | Yes | No | 9. High Cholesterol    | Yes | No |
| 5. Carotid Artery Disease     | Yes | No | 10. Diabetes           | Yes | No |

Have any of your immediate family members (parents, siblings, children) been diagnosed with any of the medical conditions listed here? If so, please list: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Are you a current smoker? Yes No If yes, how much per week? \_\_\_\_\_

Do you consume alcohol? Yes No If yes, how much per week? \_\_\_\_\_

**Release Form:**

I understand that I am voluntarily requesting to participate in the McLaren Heart Health & Stroke Risk Assessment Screening. The screening is being provided to assist me in identifying area(s) in my lifestyle that may contribute to poor health. I understand this screening includes drawing blood for cholesterol and glucose levels, an assessment of my pulse and blood pressure and my carotids assessed for bruits. I also understand the purpose and value of this program is primarily educational and is not meant to diagnose or treat any specific illness or disease. I also understand it is my sole responsibility to initiate a follow-up examination with my physician. I agree to voluntarily release McLaren, their employees, agents, volunteers, and other persons acting in any capacity on their behalf, from any and all claims or causes of action which are in any way connected to my participation in this screening. I have read and understand the above information.

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Assessments:**

**Sleep Disorder Risk Assessment & Recommendation**

Risk: \_\_\_\_\_ Recommended Sleep Study  Yes  No

**Blood Pressure Results & Recommendations**

Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ (left arm) \_\_\_\_\_ / \_\_\_\_\_ (right arm)  
Systolic Diastolic Systolic Diastolic

- |  |  |
|--|--|
| <input type="checkbox"/> Normal (Systolic: less than 120/Diastolic: less than 80)                | Continue routine blood pressure checks |
| <input type="checkbox"/> Elevated (Systolic: 120-129/Diastolic: less than 80)                    | Follow-up with physician at next visit |
| <input type="checkbox"/> Hypertension: Stage 1 (Systolic: 130-139/Diastolic: 80-89)              | Follow-up with physician within 1 week |
| <input type="checkbox"/> Hypertension: Stage 2 (Systolic: 140 or higher/Diastolic: 90 or higher) | Follow-up with physician immediately   |
| <input type="checkbox"/> Hypertensive Crisis (Systolic: 180 or higher/Diastolic: 120 or higher)  | Emergency care needed                  |

**Pulse Assessment**

Pulse Rate: \_\_\_\_\_  Regular  Irregular

**Carotid Bruit Assessment**

- Bruit Not Detected  
 Bruit Detected (check box where detected)  Right  Left  Both  
 Bruit Screening Not Done

**Cholesterol Results**

- |  |   |   |
|--|---|---|
| Total Cholesterol: _____                                 | *LDL Cholesterol: _____                                     | **HDL Cholesterol: _____                                    |
| <input type="checkbox"/> Desirable (Less than 200 mg/dL) | <input type="checkbox"/> Optimal (Less than 100 mg/dL)      | <i>Results for Women</i>                                    |
| <input type="checkbox"/> Borderline High (200-239 mg/dL) | <input type="checkbox"/> Near/Above Optimal (100-129 mg/dL) | <input type="checkbox"/> Low (Less than 50 mg/dL)           |
| <input type="checkbox"/> High (240 mg/dL or higher)      | <input type="checkbox"/> Borderline High (130-159 mg/dL)    | <input type="checkbox"/> More Desirable Level (50-59 mg/dL) |
| Triglycerides: _____                                     | <input type="checkbox"/> High (160-189 mg/dL)               | <input type="checkbox"/> High (60 mg/dL and above)          |
| <input type="checkbox"/> Normal (Less than 150 mg/dL)    | <input type="checkbox"/> Very High (190 mg/dL and above)    | <i>Results for Men</i>                                      |
| <input type="checkbox"/> Borderline High (150-199 mg/dL) |   | <input type="checkbox"/> Low (Less than 40 mg/dL)           |
| <input type="checkbox"/> High (200-499 mg/dL)            |   | <input type="checkbox"/> More Desirable Level (40-59 mg/dL) |
| <input type="checkbox"/> Very High (500 mg/dL and above) |   | <input type="checkbox"/> High (60 mg/dL and above)          |

*\*LDL Cholesterol below 70 mg/dL is best for people who have coronary artery disease, including a history of heart attacks, angina, stents or coronary bypass.*

*\*\*With HDL cholesterol, higher levels are better. Low HDL cholesterol puts you at higher risk for heart disease.*

**Glucose Results**

Glucose: \_\_\_\_\_  
 Normal (70-99 mg/dL)  Pre-Diabetes (100-125 mg/dL)  Diabetes (126 mg/dL or higher)

**Action Plan**

See your doctor to check:  Blood Pressure  Pulse  Carotid Bruit  
 Cholesterol  Glucose  Sleep Study  Other: \_\_\_\_\_

When:  Immediately  Within a week  Within 3 months  
 At your next scheduled visit

Other Considerations:  Quit Smoking  Exercise Program  
 Healthy Eating  Weight Reduction  Other: \_\_\_\_\_

Notes: \_\_\_\_\_

Screening Results Reviewed by: \_\_\_\_\_