OMB # 0925-0414 Exp: 4/06

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- Affix label here-

Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __

First Name _____M.I._____

Last Name _____

1. Date of Exam: ⌊_|_⌋-⌊_|_⌋-⌊_|_⌋ (M/D/Y)

2. Performed By: ⌊_|_|_⌋ _____

3. Contact Type:

   ☐ 1 Phone
   ☐ 2 Mail
   ☐ 3 Visit
   ☐ 8 Other

4. Visit Type:

   ☐ 1 Screening #⌊_⌋
   ☐ 2 Semi-Annual #⌊_|_⌋
   ☐ 3 Annual #⌊_|_⌋
   ☐ 4 Non-routine

5. Resting pulse in 30 sec.: ⌊_|_|_⌋ x 2 = _____/min

6. Blood pressure: 6.1. ⌊_|_|_⌋/⌊_|_|_⌋ Systolic/Diastolic

   6.2. ⌊_|_|_⌋/⌊_|_|_⌋ Systolic/Diastolic

   Cuff used: ___S ___Reg ___L ___Th

   Side: ___L ___R

Anthropometric Measures

7. Height: ⌊_|_|_⌋.⌊_⌋ cm

8. Weight: ⌊_|_|_⌋.⌊_⌋ kg BMI _____

9. Waist circumference: (to nearest 0.5 cm) ⌊_|_|_⌋.⌊_⌋ cm

10. Hip circumference: (to nearest 0.5 cm) ⌊_|_|_⌋.⌊_⌋ cm

K _____ V _____