GRADE 5
Healthy Heart Schools' Program
2010-2011 Assessment Booklet

Allied Health Centre, 5673 North Street, First Floor, Niagara Falls, Ontario L2G 1J4 Tel: 905-358-5552 Fax: 905-358-6033 info@heartniagara.com

Dear Parent/Guardian,

Recently the newspapers and TV channels have been full of stories on bad nutrition and lack of activity, smoking, and their impact on our health. Especially on heart health: on future heart attack and stroke. What the stories do not tell you is that the underlying causes of future heart disease begins in young childhood. "Hardening of the arteries" can actually begin before they reach 10 years old. Those underlying causes are levels of blood cholesterol, blood pressure and blood glucose. And these are often associated with a family history of those conditions, or of heart disease itself, in grandparents or parents. Good nutrition, proper weight management, daily activity and not smoking protect against those underlying causes.

But most people are not aware that they have underlying causes of future heart problems. They do not know their blood pressure or blood cholesterol or blood glucose levels and do not always connect them to their grandmother's stroke or their father's heart attack. Certainly not young children at school. Yet this is the very time when the gradual damage to the inside of the heart artery wall starts. This is the time for families to make positive informed choices.

The only place in Canada where all families can get information early enough to assist them in making informed healthy choices is in Niagara. For 25 years Heart Niagara and our partners at Public Health and the School Boards have provided grade 9 curriculum enrichment programs to assist students and their families to better understand possible risk factors for future heart disease. Heart Niagara is extending this program to support Grade 5 health education and teachers to increase the potential for helping students and parents make informed choices.

The health information for the program is taught by the teacher. The teachers distribute the assessment booklet for parents and students to review. The booklet is filled in by the student and parents, and includes a consent form for an assessment by Heart Niagara health professionals and follow-up research. The assessment includes a simple finger prick test which measures cholesterol, a blood pressure check, and, height, weight and waist circumference.

Your child will receive a take home sheet with some of their results along with the key information. A letter will be sent to all parents with a more complete profile of their child's results. This profile is also sent to the student's physician or nurse practitioner.

❑ Please complete and sign the front page. ❑ Please complete the family history on page 2.

In signing this consent, you understand the following:

- That all participation is voluntary and can be withdrawn at any time.
- That all information provided will be handled in a confidential manner and stored in a secure and private location.
- That involvement poses minimal risk to participants.
- That a nurse may refer your child to a family physician and/or other appropriate health professional under certain circumstances for follow-up.
- That the results will be used: to educate your child regarding a healthy heart lifestyle; for assessment and awareness purposes; potential follow-up; and for research purposes.
- That all data collected and used for research purposes will be used to study trends and no individual data will appear in reports, only aggregate, anonymous, and summary data to respect the anonymity of the participants.
- That you can contact Heart Niagara at 905-358-5552 to ask any additional questions.
- That it is suggested you keep a copy of this signed consent for your files.
- I hereby authorize my family doctor, nurse practitioner or pediatrician to release to Heart Niagara medical information relevant to the Healthy Heart Schools' Program for research purposes for a period of 12 months following my child's assessment. I understand that I can withdraw this authorization at any time by notifying Heart Niagara Inc. in writing.

Today's Date: D D M M Y Y Y Y Student Name: ______________ FIRST ______________ LAST

has my consent to participate in a finger prick cholesterol test on D D M M Y Y Y Y Student Health Card #: ______________ ____ VERSON CODE

Family Doctor/Nurse Practitioner: ______________ FIRST ______________ LAST

Parent/Guardian: ______________ FIRST ______________ LAST

Parent/Guardian Signature: ______________ Student Signature: ______________

Heart NIAGARA Family Health History Assessment

www.heartniagara.com

1) **How many full sisters and brothers (share both parents) do you have?** ____________

2) **How many half sisters and brothers (share 1 of 2 parents) do you have?** ____________

These questions are only about your biological family.
Do not include people living with you who are not directly related to you.

3) **Do any of the following members of your family have diabetes?**
Mother ❑Yes ❑No Father ❑Yes ❑No

a. How many full sisters and brothers have diabetes?	❑None	❑1	❑2	❑3+
b. How many half sisters and brothers have diabetes?	❑None	❑1	❑2	❑3+
c. How many grandparents have diabetes?	❑None	❑1	❑2	❑3+

4) **Do any members of your family have high blood pressure *(hypertension)*?**
Mother ❑Yes ❑No Father ❑Yes ❑No

a. How many full sisters and brothers have high blood pressure?	❑None	❑1	❑2	❑3+
b. How many half sisters and brothers have high blood pressure?	❑None	❑1	❑2	❑3+
c. How many grandparents have high blood pressure?	❑None	❑1	❑2	❑3+

5) **Do any members of your family have high cholesterol *(hyperlipidemia)*?**
Mother ❑Yes ❑No Father ❑Yes ❑No

a. How many full sisters and brothers have high cholesterol?	❑None	❑1	❑2	❑3+
b. How many half sisters and brothers have high cholesterol?	❑None	❑1	❑2	❑3+
c. How many grandparents have high cholesterol?	❑None	❑1	❑2	❑3+

6) **Have any members of your family ever had a stroke?**
Mother ❑Yes ❑No Father ❑Yes ❑No

a. How many full sisters and brothers have had a stroke?	❑None	❑1	❑2	❑3+
b. How many half sisters and brothers have had a stroke?	❑None	❑1	❑2	❑3+
c. How many grandparents have had a stroke?	❑None	❑1	❑2	❑3+

7) **Have any members of your family ever had angina *(chest pain)* or a heart attack?**
Mother ❑Yes ❑No Father ❑Yes ❑No

a. How many full sisters and brothers have had either?	❑None	❑1	❑2	❑3+
b. How many half sisters and brothers have had either?	❑None	❑1	❑2	❑3+
c. How many grandparents have had either?	❑None	❑1	❑2	❑3+

8) **Have any members of your family ever had heart/bypass surgery?**
Mother ❑Yes ❑No Father ❑Yes ❑No

a. How many full sisters and brothers have had heart/bypass surgery?	❑None	❑1	❑2	❑ 3+
b. How many half sisters and brothers have had heart/bypass surgery?	❑None	❑1	❑2	❑ 3+
c. How many grandparents have had heart/bypass surgery?	❑None	❑1	❑2	❑ 3+

9) ***Before the age of 65,***
Have any female members of your family had angina, heart attack, heart/bypass surgery or a stroke ?
Mother ❑Yes ❑No Grandmothers ❑Yes ❑No

10) ***Before the age of 55,***
Have any male members of your family had angina, heart attack, heart/bypass surgery or a stroke ?
Father ❑Yes ❑No Grandfathers ❑Yes ❑No

❑ Reviewed by
HEART NIAGARA STAFF

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Personal Health Assessment

1) **Are you trying to, or have you ever tried to lose weight?** ☐Yes ☐No

2) **Would you like to:**
☐Weigh more ☐Weigh less ☐Have weight stay about the same

3) **Compared to other students in your grade who are as tall as you, do you think you weigh:**
☐The right amount ☐Too much ☐ Too little

4) **Has your doctor or nurse practitioner ever told you that you have diabetes?** ☐Yes ☐No
If no, skip to question 5.
a. If yes to 4, are you taking medication to control your diabetes other than insulin? ☐Yes ☐No
b. If yes to 4, are you taking insulin to control your diabetes? ☐Yes ☐No

5) **Has your doctor or nurse practitioner ever told you that you have high blood pressure *(hypertension)*?** If no, skip to question 6. ☐Yes ☐No
a. If yes to 5, are you taking medication to control your blood pressure? ☐Yes ☐No

6) **Has your doctor or nurse practitioner ever told you that you have high cholesterol (hyperlipidemia)?** If no skip to question 7. ☐Yes ☐No
a. If yes to 6, are you taking medication to control your high cholesterol? ☐Yes ☐No

7) **Has your doctor or nurse practitioner ever told you that you have low HDL cholesterol *(good cholesterol)*?** ☐Yes ☐No

8) **How would you rate your overall health?** ☐Poor ☐Fair ☐Good ☐Very Good ☐Excellent

9) **How would you rate your stress level?** ☐Poor ☐Fair ☐Good ☐Very Good ☐Excellent

smoking

Contact www.smokershotline.ca

1 - Do any of your family members smoke?
Yes ☐ No ☐

2 - Does anyone smoke in your home?
a) No - Our house is a smoke-free house ☐
b) No - But guests do ☐
c) Yes - In most areas ☐
d) Yes - In designated smoking room ☐
e) Yes - Outside only ☐

3 - Do your friends smoke?
Yes ☐ No ☐

4 - Have your friends ever tried smoking, even just a few puffs?
Yes ☐ No ☐

5 - If one of your friends asked you to smoke a cigarette, would you?
Yes ☐ No ☐

6 - Do you smoke?
Yes ☐ No ☐
(If you answered no, go to question 10)

6 - *Think about the last 30 days.* Did you smoke a cigarette, even a puff?
a) Everyday or almost every day ☐
b) Some days ☐
c) 1 or 2 days ☐
d) None at all ☐

7 - Would you consider yourself to be a:
a) Ex-smoker who has totally quit ☐
b) Non-smoker, who sometimes smokes ☐
c) Light smoker ☐
d) Medium smoker ☐
e) Heavy smoker ☐

8 - *Think about the last 30 days.* On the days that you smoked, how many cigarettes did you smoke?
a) A few puffs only ☐
b) 1 - 2 per day ☐
c) 3 - 5 per day ☐
d) 6 - 10 per day ☐
e) 11 - 19 per day ☐
g) 20 or more per day ☐

9 - *Think about the next 6 months.* Do you plan on quitting smoking?
Yes ☐ No ☐
If Yes check one
a) Within the next week ☐
b) Within the next month ☐
c) Within the next 3 months ☐
d) More than 3 months from now ☐

10 - *If you are an ex-smoker,* how long have you been smoke free?
a) More than a year ☐
b) Between 6 months and one year ☐
c) Less than 6 months ☐
d) I still consider myself a smoker ☐

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NUTRITION

These questions are about *YESTERDAY.*

✓ CHECK ONLY ONE ANSWER PER QUESTION

#	Question	NONE	1 TIME	2 TIMES	3 OR MORE
1.	***Yesterday,*** how many times did you eat hamburger, hot dogs, sausage, steak, bacon or ribs?				
2.	***Yesterday,*** how many times did you eat battered or fried chicken, chicken nuggets, fried steak, fried pork chops, or fried fish?				
3.	***Yesterday,*** how many times did you eat peanuts or peanut butter?				
4.	***Yesterday,*** how many times did you eat any kind of cheese, cheese spread or a cheese sauce? Include cheese on pizza or in dishes such as tacos, enchiladas, lasagna, sandwiches, cheeseburgers or macaroni and cheese.				
5.	***Yesterday,*** how many times did you drink any kind of milk? *Include chocolate or other flavored milk; almond, rice or soy milk; milk on cereal, and drinks made with milk (like milkshakes).*				
6.	***Yesterday,*** how many times did you eat yogurt or cottage cheese or drink a yogurt drink? *Do not count frozen yogurt.*				
7.	***Yesterday,*** how many times did you eat rice, macaroni, spaghetti, or pasta noodles?				
8.	***Yesterday,*** how many times did you eat any white bread, buns, bagels, tortilla, or rolls?				
9.	***Yesterday,*** how many times did you eat any whole wheat or dark bread, buns, bagels, tortillas, or rolls?				
10.	***Yesterday,*** how many times did you eat hot or cold cereal?				
11.	***Yesterday,*** how many times did you eat french fries or chips? *Include potato chips, tortilla chips, Cheetos®, corn chips, or other snack chips.*				
12.	***Yesterday,*** how many times did you eat vegetables? *Include all cooked and uncooked vegetables; salads; and boiled, baked and mashed potatoes. Do not count french fries or chips.*				
13.	***Yesterday,*** how many times did you eat beans such as pinto beans, baked beans, kidney beans, refried beans, or pork and beans? *Do not count green beans.*				
14.	***Yesterday,*** how many times did you eat fruit? *Do not count juice.*				
15.	***Yesterday,*** how many times did you drink fruit juice? *Fruit juice is 100% juice drink like orange juice, apple juice, or grape juice. Do not count punch, Kool-Aid®, sport drinks, and other fruit flavored drinks.*				
16.	***Yesterday,*** how many times did you drink any punch, Kool-Aid®, sports drinks, or other fruit-flavored drinks? *Do not count fruit juice.*				
17.	***Yesterday,*** how many times did you drink any regular (not diet) sodas or soft drinks?				
18.	***Yesterday,*** how many times did you drink any diet sodas or soft drinks?				
19.	***Yesterday,*** how many times did you eat some type of frozen dessert? *A frozen dessert is a cold, sweet food like ice cream, frozen yogurt, an ice cream bar, or a popsicle.*				
20.	***Yesterday,*** how many times did you eat sweet rolls, doughnuts, cookies, brownies, pies or cakes?				
21.	***Yesterday,*** how many times did you eat chocolate candy? *Do not count brownies or chocolate cookies.*				
22.	***Yesterday,*** how many meals did you eat? *Meals include breakfast, lunch and dinner.*				
23.	***Yesterday,*** how many times did you eat food from any type of restaurant? *(Restaurants include fast food, sit down restaurants, pizza places, and cafeterias).*				
24.	***Yesterday,*** how many times did you eat or drink a snack? *A snack is any food or beverage that you eat or drink before, after, or between meals (not water).*				

25. What kind of milk do you usually drink?

- ❑ Regular (whole) milk
- ❑ Low-fat (2%, 1 ½%, 1%) milk
- ❑ Skim, nonfat, or ½% milk
- ❑ Soy, almond or rice milk
- ❑ Combination of the above types of milk
- ❑ I don't drink milk

26. Are you a vegetarian?

- ❑ No, I eat meat (beef, pork, fish, or chicken).
- ❑ Yes, but sometimes I eat meat (beef, pork, fish, or chicken).
- ❑ Yes, I never eat meat (beef, pork, fish, or chicken).

27. When you think about the way you usually eat, would you say that your eating habits are:

- ❑ Much healthier than those of most people my age
- ❑ Somewhat healthier than those of most people my age
- ❑ About the same as those of most people my age
- ❑ Somewhat less healthy than those of most people my age
- ❑ Much less healthy than those of most people my age

28. Do you usually eat or drink something for breakfast?

- ❑ Almost always or always
- ❑ Sometimes
- ❑ Almost never or never

29.. How many times do you skip breakfast in one week?

_______ / 7 days

30. Do you skip meals?

❑ Yes ❑ No

31. Do you buy lunch at school *(for example, cafeteria or outside restaurant)* instead of bringing a lunch from home?

- ❑ Almost always or always
- ❑ Sometimes
- ❑ Almost never or never
- ❑ Not applicable

32. Other than the school cafeteria, how many times do you eat out in a restaurant or fast food place?

_______ / 7 days

33. From which food group *SHOULD* you eat the *MOST* servings each day?

- ❑ Breads, cereals, rice, pasta
- ❑ Dairy products (milk, cheese, yogurt)
- ❑ Fats, oils, sweets
- ❑ Fruits and vegetables
- ❑ Meats, fish, poultry, beans, eggs, nuts,
- ❑ Don't know

34. From which food group *SHOULD* you eat the *FEWEST* servings each day?

- ❑ Breads, cereals, rice, pasta
- ❑ Dairy products (milk, cheese, yogurt)
- ❑ Fats, oils, sweets
- ❑ Fruits and vegetables
- ❑ Meats, fish, poultry, beans, eggs, nuts,
- ❑ Don't know

35. How many total servings of fruits and vegetables should you eat each day?

- ❑ At least 2 servings
- ❑ At least 3 servings
- ❑ At least 4 servings
- ❑ At least 5 servings
- ❑ Don't know

36. Which contains the most calories?

- ❑ One gram of protein
- ❑ One gram of fat
- ❑ One gram of carbohydrates

37. The foods that I eat and drink are healthy so there is no reason for me to make changes.

- ❑ Agree
- ❑ Neither agree nor disagree
- ❑ Disagree
- ❑ Don't know

38. Not eating breakfast or lunch affects my ability to do well in school.

- ❑ Agree
- ❑ Neither agree nor disagree
- ❑ Disagree
- ❑ Don't know

38. I think that learning about the connection between food and health is important for students my age to know.

- ❑ Agree
- ❑ Neither agree nor disagree
- ❑ Disagree
- ❑ Don't know

40. I like to try new foods.

- ❑ Almost always or always
- ❑ Sometimes
- ❑ Almost never or never

41. How many cups of coffee, caffeinated tea, cappuccino or espresso do you have a week?

________________ cups

42. How many cups of caffeinated soft drinks *(for example, Coke ® or Pepsi ® or other cola)* do you have a week?

________________ cups

43. How many cups of hot chocolate do you have a week?

________________ cups

44. How often do you eat dinner with at least one parent during a typical week?

- ❑ 0-1 times
- ❑ 2-3 times
- ❑ 4-5 times
- ❑ 6-7 times

Sleep

1) During the past month, what time have you usually gone to bed at night on weekdays and weekends?
Bed time (weekday) ____________ **Bed time (weekend)** ____________

2) During the past month, how long (in minutes) has it usually taken you to fall asleep each night on weekdays and weekends?
Minutes (weekday) ____________ **Minutes (weekend)** ____________

3) During the past month, what time have you usually gotten up in the morning on weekdays and weekends?
Wake up time (weekday) ____________ **Wake up time (weekend)** ____________

4) During the past month, how many hours of actual sleep did you get at night on weekdays and weekends?
(This may be different than the number of hours you spent in bed.)
Hours of sleep per night (weekday) ________ **Hours of sleep per night (weekend)** ________

5) During the past month, how well have you slept on weekdays and weekends?

Weekday ☐ Very good ☐ Fairly good ☐ Fairly bad ☐ Very bad
Weekend ☐ Very good ☐ Fairly good ☐ Fairly bad ☐ Very bad

6) During the past month, how often have you taken medicine to help you sleep?

☐ Not during the past month ☐ Less than once a week ☐ Never
☐ Once or twice a week ☐ Three or more times a week

7) During the past month, how often have you had trouble sleeping because you:

	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week	Do these days include weekends
a. Could not get to sleep within 30 minutes	☐	☐	☐	☐	☐ Yes ☐ No
b. Woke up in the middle of the night or early morning	☐	☐	☐	☐	☐ Yes ☐ No
c. Had to get up to use the bathroom	☐	☐	☐	☐	☐ Yes ☐ No
d. Could not breathe comfortably	☐	☐	☐	☐	☐ Yes ☐ No
e. Coughed or snored loudly	☐	☐	☐	☐	☐ Yes ☐ No
f. Felt too cold	☐	☐	☐	☐	☐ Yes ☐ No
g. Felt too hot	☐	☐	☐	☐	☐ Yes ☐ No
h. Had bad dreams	☐	☐	☐	☐	☐ Yes ☐ No
i. Had pain	☐	☐	☐	☐	☐ Yes ☐ No
j. Other reason(s), please describe:	☐	☐	☐	☐	☐ Yes ☐ No

____

8) During the past month, how often have you had trouble staying awake while in school, while eating meals, or while being with friends?

☐ Not during the past month ☐ Less than once a week ☐ Once or twice a week ☐ Three or more times a week

9) During the past month, how much of a problem has it been for you to keep up enough energy to get things done on weekdays and weekends?

Weekdays ☐ No problem at all ☐ Slight problem ☐ A noticeable problem ☐ A very big problem
Weekends ☐ No problem at all ☐ Slight problem ☐ A noticeable problem ☐ A very big problem

10) Ask someone you live with how often, in the past month, you have had:

	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week	Do these days include weekends
a. Loud snoring	☐	☐	☐	☐	☐ Yes ☐ No
b. Long pauses between breaths while asleep	☐	☐	☐	☐	☐ Yes ☐ No
c. Legs twitching or jerking while you sleep	☐	☐	☐	☐	☐ Yes ☐ No
d. Episodes of sleepwalking or have woken up not knowing where you are	☐	☐	☐	☐	☐ Yes ☐ No
e. Other restlessness while asleep, please describe	☐	☐	☐	☐	☐ Yes ☐ No

____

Physical Activity & SEDENTARY PURSUITS

1. **On how many of the past 7 days did you exercise or take part in physical activity that made your heart beat fast and made you breathe hard for *"at least 20 minutes"*?**
   (For example: basketball, soccer, running, rugby, jogging, fast dancing, swimming laps, tennis, fast bicycling, or similar aerobic activities)
   ❑ 0 days ❑ 1 day ❑ 2 days ❑ 3 days ❑ 4 days ❑ 5 days ❑ 6 days ❑ 7 days

2. **On how many of the past 7 days did you take part in physical activity or exercise for *"at least 30 minutes"* where your heart "*did not*" beat fast or you did not breathe hard, such as fast walking, slow bicycling, skating, pushing a lawn mower, or mopping floors?**
   ❑ 0 days ❑ 1 day ❑ 2 days ❑ 3 days ❑ 4 days ❑ 5 days ❑ 6 days ❑ 7 days

3. **On how many of the past 7 days did you do exercises to strengthen or tone your muscles, such as push-ups, sit-ups, or weight lifting?**
   ❑ 0 days ❑ 1 day ❑ 2 days ❑ 3 days ❑ 4 days ❑ 5 days ❑ 6 days ❑ 7 days

4. **In one week, how many days do you go to physical education (PE) or gym class?**
   ❑ 0 days ❑ 1 day ❑ 2 days ❑ 3 days ❑ 4 days ❑ 5 days

5. **During an average physical education (PE) class, how many minutes do you spend actually exercising or playing sports?**
   ❑ I do not take PE ❑ less than 10 minutes ❑ 10-20 minutes ❑ 21-30 minutes
   ❑ 31-40 minutes ❑ 41-50 minutes ❑ 51-60 minutes ❑ More than 60 min.

6. **During the past 12 months, on how many sports teams (like a community team, summer league, school or church team) did you play?**
   For example: soccer, basketball, baseball, rugby, swimming, gymnastics, wrestling, track, football, tennis, and volleyball.
   ❑ 0 teams ❑ 1 team ❑ 2 teams ❑ 3 teams or more

7. **Do you participate in any other organized physical activities or take lessons, such as martial arts, dance, gymnastics or fitness class?**
   ❑ Yes ❑ No

8. **How many hours per day do you usually watch TV or video movies away from school?**
   ❑ 0 hours ❑ 3 hours
   ❑ less than 1 hour ❑ 4 hours
   ❑ 1 hour ❑ 5 hours
   ❑ 2 hours ❑ 6 hours or more

9. **How many hours per day do you usually spend on the computer away from school?**
   (Time on the computer includes time spent surfing the internet and instant messaging, as well as doing homework).
   ❑ 0 hours ❑ 3 hours
   ❑ less than 1 hour ❑ 4 hours
   ❑ 1 hour ❑ 5 hours
   ❑ 2 hours ❑ 6 hours or more

10. **How many hours per day do you usually spend playing video games like Nintendo®, Sega®, PlayStation®, Xbox®, GameBoy® or arcade games away from school?**
    ❑ 0 hours ❑ 3 hours
    ❑ less than 1 hour ❑ 4 hours
    ❑ 1 hour ❑ 5 hours
    ❑ 2 hours ❑ 6 hours or more

11. **I think that learning about the connection between physical activity and health is important for students my age to know.**
    ❑ True ❑ False

Heart NIAGARA www.heartniagara.com

GRADE 5
Healthy Heart Schools' Program
2010-2011 Assessment Booklet

Student Information - *please print* **Case Number 2010** 5

School Name

Name (FIRST, LAST)

Male Female Date of Birth D D M M Y Y Y Y Age

Address (NUMBER, STREET, UNIT/APARTMENT)

City Postal Code

Parent/Guardian's Name (FIRST, LAST)

Home Phone Work Phone Ext

Healthcare Provider Contact Information - *Do you have a family doctor?* YES NO
Do you have a nurse practitioner? YES NO

Healthcare Provider (FIRST, LAST)

Address (NUMBER, STREET, UNIT)

City Postal Code Phone

DO NOT WRITE IN THIS AREA *To be filled in by clinical staff.*

Weight	*Kilograms*	**Height**	*Centimetres*	**Waist (Circumference)**	*Centimetres*
Body Mass Index(BMI)		**StatCoder**		**Family History Review**	Mom Y N Dad Y N
Blood Pressure	*Systolic*		*Diastolic*		☐ *<50* ☐ *<90* ☐ *<95* ☐ *≥95* ☐ *≥99* ☐ *AVG*

Run Stage *(Shuttle run)*		TC = mmol/L HDL = mmol/L Non HDL = mmol/L TC/HDL =
Have you tried smoking, even just a few puffs?	☐ Yes ☐ No CONFIDENTIAL	
How many times have you tried smoking?	1 2 3 4 5+ TIME(S)	**No Cholesterol Result** ☐ No Consent ☐ Declined test ☐ Equipment failure ☐ Unable to get sample ☐ Absent ☐ Declined all
Do you smoke now?	☐ Yes ☐ No CONFIDENTIAL	
If yes, do you want help to quit?	☐ Yes ☐ No CONFIDENTIAL	