OMB # 0925-0414 Exp: 5/03

- 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 _____