# High Blood Pressure Screening Tool

***Read the following questions to your clients. Refer them to the clinic for a blood pressure check if the answer to ANY of the questions is YES.***

| Question | YES | NO |
|---|---|---|
| 1. Do you have very bad headaches? | Y | N |
| 2. Do you feel tired or confused? | Y | N |
| 3. Do you feel dizzy? | Y | N |
| 4. Do you feel like vomiting? | Y | N |
| 5. Do you have blurry eyesight? | Y | N |
| 6. Do you have chest pains? | Y | N |
| 7. Do you have shortness of breath? | Y | N |
| 8. Does it feel like your heart is beating too fast? | Y | N |
| 9. Is there blood in your urine? | Y | N |
| 10. Do you feel a pounding in the chest, in your neck or ringing in the ears? | Y | N |
| 11. Do you have swollen ankles? | Y | N |

**Note to CHW: <u>ONLY</u>** a clinical health worker can diagnose high blood pressure.

**See Health For All Health Promotion Tool pages 134-137 for more on high blood pressure.**

# Warning Signs for Diabetes Checklist

| Warning Signs | YES | NO |
|---|---|---|
| Do you feel very thirsty? | Y | N |
| Do you urinate a lot? | Y | N |
| Do you feel very tired a lot of the time? | Y | N |
| Do you feel very hungry a lot of the time? | Y | N |
| Are you losing weight without trying to? | Y | N |
| Do you have blurry eyesight? | Y | N |
| Do you have dry, itchy skin? | Y | N |
| Do you have sores that take a long time to heal? | Y | N |
| Are you losing feeling or getting a tingling feeling in your feet? | Y | N |

Make sure that household members understand the importance of getting help as soon as possible if they have

**ANY** of these signs, especially if they have any of the risk factors for diabetes.

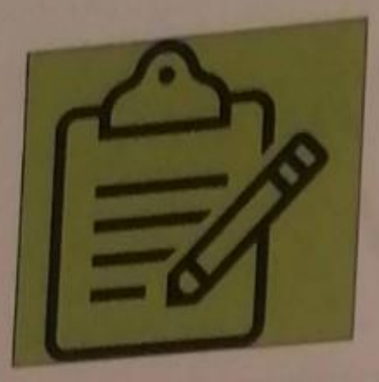
**See Health For All Health Promotion Tool pages 138-143 for more on diabetes.**

# Pregnancy Screening Tool

***Read the following questions to your female clients, ages 14-45 or as appropriate. Refer them to the clinic for a pregnancy test if the answer to Question 1 shows that they have missed a period and the answer to ANY of the other questions is YES.***

| Question | | |
|---|---|---|
| 1. When was the first day of your last normal menstrual period? (Your normal period is the period you have every month; this may be different from other women, e.g. the flow may be heavier, the number of days may be different.) | **Day** ____ | **Month** ____ |
| **Question** | **YES** | **NO** |
| 2. Have you been having sex without using any form of contraceptive? | **Y** | **N** |
| 3. Are your breasts tender? | **Y** | **N** |
| 4. Have you been feeling nauseous? | **Y** | **N** |
| 5. Do you feel tired all the time? | **Y** | **N** |

**Note to the CHW:** Use the Pregnancy Planner Wheel to determine whether the date of last menstrual period indicates a missed period and possible pregnancy.



# TB Screening Tool for Adults

***Read the following questions to all individuals in the household and refer them to the clinic for TB testing if you tick YES (in the coloured blocks) for any answer.***

| Question | YES | NO |
|---|---|---|
| 1. Do you have a cough? | Y | N |
| If YES, ask: For how long have you been coughing? | | |
| 2. Do you have a fever? | Y | N |
| If YES, ask: For how long have you had a fever? | | |
| 3. Have you lost weight? | Y | N |
| If YES, ask: What do you think might be the cause of you losing weight? | | |
| 4. Are you sweating a lot at night? | Y | N |

**Note to the CHW:** Please read the following to the community member.

If you are HIV-positive and you have been coughing for 24 hours, you should go to the clinic as soon as possible for a TB test.

If you are HIV-positive, you should be screened for TB whenever you go for your check-up appointments at the clinic.

**See Health For All Health Promotion Tool pages 130-133 for more on TB.**

# TB Screening Tool for Children

***Read the following questions to any child and/or their caregiver in the household and refer them to the clinic for TB testing if you tick YES (in the coloured blocks) for any answer.***

| Question | YES | NO |
|---|---|---|
| 1. Do you have a cough? / Does the child have a cough that has not improved despite treatment? | Y | N |
| If YES, ask: For how long have you/has she or he been coughing? | | |
| 2. Do you have a fever? /Does the child have a fever | Y | N |
| If YES, ask: For how long have you/has she or he had a fever? | | |
| 3. Have you lost weight? /Has the child lost weight? | Y | N |
| If YES, ask: What do you think might be the cause of you/she or he losing weight? | | |
| 4. Are you feeling tired? / Has the child been feeling tired or been less playful? | Y | N |

**See Health For All Health Promotion Tool pages 130-133 for more on TB.**

# Treatment Adherence Checklist

| | Done | Not Done |
|---|---|---|
| **Reviews treatment history, including:** | | |
| • Current regimen | | |
| • Side effects | | |
| • Other treatments | | |
| **Discusses current health status with patient, including:** | | |
| • Overall health and current problems | | |
| • Latest relevant laboratory tests (e.g. CD4 count) | | |
| • Goals for health | | |
| **Assesses patient's medication knowledge, behaviours, and attitudes, including:** | | |
| • Knowledge of HIV/TB/other medications | | |
| • Understanding of drug resistance and implications | | |
| • Attitudes about taking medications | | |
| **Reviews patient's/family's living situation, including:** | | |
| • Daily activities: work, school and travel schedule | | |
| • Eating patterns | | |
| • Access to health centre | | |
| • Special factors: disclosure of diagnosis, medication storage issues | | |
| **Describes proposed medication regimen, including:** | | |
| • Drug names | | |
| • Dosing | | |
| • Food requirements | | |
| • Special instructions/how to give | | |