

Republic of the Philippines
Department of Education
Region VII, Central Visayas
DIVISION OF CITY SCHOOLS-TAGBILARAN
Tagbilaran City

October 13, 2014

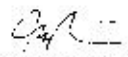
DIVISION MEMORANDUM
No. 185 s. 2014

BP NG TEACHER KO ALAGA KO

To: FPS 1/PSDS
All Public School Heads (Elem & HS)
All Non-Teaching Personnel

1. The Department of Education (DepEd) through the Health & Nutrition Center in Collaboration with Liri-Therapharma, Philippine Society of Hypertension (PSH) and Philippine Heart Association (PHA) will implement the project "BP ng Teacher Ko Alaga Ko". This project will provide free blood pressure (BP) taking, fasting blood sugar (FBS) testing, electrocardiogram (ECG) and cholesterol screening for teachers and non-teaching personnel on October 17, 2014 at the Division Office, 7:00 in the morning. It aims to establish the prevalence of hypertension among public school teachers to increase their level of awareness on the importance of blood pressure monitoring and healthy lifestyle.

2. All personnel who will undergo for screening are advised to observe fasting the night before the test.
3. Please find the attached forms to be accomplished by the teachers before they submit themselves for the screening.
4. Immediate dissemination of this Memorandum is desired.


EVANGEL M. LUMINARIAS, Ph.D.
Schools Division Superintendent

Dear Sir/Mam,

The Department of Education in collaboration with the Philippine Heart Association, Philippine Society of Hypertension and with the support from LRI-Therapharma would like to invite you to avail of the **FREE SCREENINGS and CONSULTATION** on _____, 2014, 7:00 am to 11:00 am at _____.

We will help you check the following:

- Blood Pressure (BP)
- Fasting Blood Sugar (FBS)
- Cholesterol
- Electrocardiogram (ECG)

We would like to request you to fast (no food and water intake after 10:00 pm) the night before your scheduled date.

We look forward to your participation. We are one in our goal to a healthy heart to avoid cardiac arrest, stroke and any cardiovascular diseases.

Sincerely yours,

Department of Education
Philippine Heart Association
Philippine Society of Hypertension
LRI-Therapharma



ASSESSMENT AND SCREENING FORM

(Please answer carefully). Pakisagot ng maingat at tapat.

First Name: _____ Age _____
 Last Name: _____ Sex ()M ()F
 Address: _____
 Cell number: _____
 School: _____
 Position: _____
 Grade Level: _____
 Years of Service: _____
 Status: Married _____ Single _____ Widow _____ Others _____
 Spouse Occupation: _____ No. of Children: _____

Please Check:

	YES	NO
1. Do you have a family history of. <i>(mother, father, sister, brother or grandparents with)</i>		
a. Stroke ("Alako")	<input type="checkbox"/>	<input type="checkbox"/>
b. Heart Disease ("Sakit sa puso")	<input type="checkbox"/>	<input type="checkbox"/>
c. Diabetes ("Diyabeles")	<input type="checkbox"/>	<input type="checkbox"/>
d. Obesity ("Labis na katabaan")	<input type="checkbox"/>	<input type="checkbox"/>
e. Hypertension ("High blood o altaprosyon")	<input type="checkbox"/>	<input type="checkbox"/>
f. Peripheral Vascular Disease ("Baradong ugat sa binti")	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a father or a brother who had a heart attack before the age of 50 (<50 years old)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have a mother or a sister who had a heart attack before the age of 65 (<65 years old)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your doctor or nurse ever told you that you have the following:		
a. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
b. Hypercholesterolemia ("Mataas na kolesterol")	<input type="checkbox"/>	<input type="checkbox"/>
c. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
d. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
e. Coronary Disease ("Baradong ugat sa puso")	<input type="checkbox"/>	<input type="checkbox"/>
f. Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever experienced:		
a. Any pain in your chest during the last two years?	<input type="checkbox"/>	<input type="checkbox"/>
b. Any tightness or heaviness in your chest during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>
c. Sudden weakness, heaviness or numbness in ONE side or part of the body for more than five minutes? (For example: sudden face, arm or leg weakness or numbness)	<input type="checkbox"/>	<input type="checkbox"/>
If YES to c, did the weakness, heaviness or numbness last for more than 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>
d. Sudden slurring of speech or inability to say what you want to say that LASTED for more than five minutes?	<input type="checkbox"/>	<input type="checkbox"/>
If YES to d, did the slurring last for more than 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>
6. My blood pressure is: (Please check ONE)		
<input type="checkbox"/> More than 140/90 mmHg		
<input type="checkbox"/> Equal to 140/90 mmHg		
<input type="checkbox"/> Between 120/80 to 139/89 mmHg		
<input type="checkbox"/> Less than 120/80 mmHg		
<input type="checkbox"/> I can't remember but I had it checked		
<input type="checkbox"/> I don't know, I never had it checked		
6. a)	YES	NO
I take medicine to control my blood pressure	<input type="checkbox"/>	<input type="checkbox"/>

7. My total blood cholesterol level is: (Please check ONE)

- Less than or equal to 200 mg/dL
- More than 200 mg/dL
- I can't remember but I had it checked
- I don't know, I never had it checked

YES NO

7.a) I was prescribed diet and cholesterol lowering pills

8. My HDL-C (good cholesterol) level is: (Please check ONE)

- Less than 40 mg/dL
- More than 40 mg/dL
- I can't remember but I had it checked
- I don't know, I never had it checked

10. My weight is: (Please check ONE)

- Within my ideal weight
- 20 lbs or more in excess of my ideal weight
- I don't know my ideal weight

11. My fasting blood sugar (FBS) level is: (Please check ONE)

- More than 126 mg/dL
- Equal to 100 mg/dL
- Less than 100 mg/dL
- I can't remember but I had it checked
- I don't know, I never had it checked

YES NO

11. a) I need medicine to control my blood sugar (Pills or Insulin)

YES NO

12. Do you engage on a regular exercise?

If YES, how often? _____ (number of times/week)

How long (time spent)? _____ mins

13. Do you NOW smoke cigarettes, cigars, pipes or any tobacco products? (Please check ONE)

- No, not at all
- Yes, but less often than weekly
- Yes but not everyday but at least one day a week
- Yes, everyday (at least one cigarette per day)

14. In the PAST, did you ever smoke cigarettes, cigars, pipes or other tobacco products? (Please check ONE)

- Yes, daily
- Yes, 100 or more cigarettes, but never daily
- No, not at all, or less than 100 cigarettes in my lifetime

YES NO

15. I live or work with people who smoke regularly.

16. Describe your salt intake (preferences for processed meats, salted fish, salted eggs, salty condiments e.g. "patis", soy sauce, "bagoong", etc.)

(Gaano ka kahilig sa maaalat na pagkain - mga karneng 'processed', tuyo, tinapa, bagoong, itlog na manlat, toyo, patis, bagoong, at iba pa)

- Light (Kaunti)
- Moderate (Malakas)
- Excessive (Sobrang malakas)

17. Indicate by checking the frequency of meal/drink preferences at home.

(Sagutin at lagyan ng tsek ayon sa dalas ng mga karaniwang pagkain at inumin sa bahay.)

	Very frequently Napakadulas	Frequently Madalas	Occasional Minsan	Never Wala
Fruits				
Vegetables				
Pork				
Beef				
Poultry				
Nuts/grains (ex. mungo, peas, etc.)				
Alcohol				
Junk food (ex. chips, fries, candies, etc.)				