

PRE POST

NAME _____ DATE _____



Clinical Data Collection Form

Test	Value		Check if participant opted out of test
Total Cholesterol (mg/dL)			<input type="checkbox"/>
Triglycerides (mg/dL)			<input type="checkbox"/>
LDL Cholesterol (mg/dL)			<input type="checkbox"/>
HDL Cholesterol (mg/dL)			<input type="checkbox"/>
HbA1c (%)			<input type="checkbox"/>
Blood pressure #1 (mmHg)			<input type="checkbox"/>
Blood pressure #2 (mmHg)			<input type="checkbox"/>
Waist circumference (in)			<input type="checkbox"/>
Height (in)			<input type="checkbox"/>
Body weight #1 (lbs)			<input type="checkbox"/>
Body weight #2 (lbs)			<input type="checkbox"/>