PRE POST NAME_____ DATE _____

FARMACY Rx

Clinical Data Collection Form

Test	Value		Check if participant opted out of test
Total Cholesterol (mg/dl)			☐
HbA1c (%)			☐
Blood pressure #1 (mmHg)			☐
Blood pressure #2 (mmHg)			☐
Waist circumference (in)			☐
Height (in)			☐
Body weight #1 (lbs)			☐
Body weight #2 (lbs)			☐