### Clinic Check off Sheet

**Participant Id#:**

**Exam 4**

**Clinic Exam Date: _ _ / _ _ / _ _ _**

<table>
<thead>
<tr>
<th>Order</th>
<th>Start Time</th>
<th>End Time</th>
<th>Form / Procedure</th>
<th>Comments / Notes</th>
<th>Tech ID</th>
</tr>
</thead>
</table>
| 1     |            |          | Reception (Consent & Participant Contact Form)  
Meds: Y  N  S  Diabetic: Y  N  Fasting Time: _______ |                  |         |
| 2     |            |          | Anthropometry    |                  |         |
| 3     |            |          | Seated Blood Pressure  
Cuff size: ______  Arm Circum: ________ |                  |         |
| 4     |            |          | Phlebotomy       |                  |         |
| 5     |            |          | Snack            |                  |         |
|       |            |          | Medical History  |                  |         |
|       |            |          | Medications      |                  |         |
|       |            |          | Personal History |               |         |
|       |            |          | Completed in clinic |         |         |
|       |            |          | Sent home with participant |    |         |
|       |            |          | Health and Life Questionnaire | |         |
|       |            |          | Sleep Questionnaire |               |         |
|       |            |          | Exit             |                  |         |
|       |            |          | MHI Appointment  |                  |         |
|       |            |          | Day:             |                  |         |
|       |            |          | Date:            |                  |         |
|       |            |          | Time:            |                  |         |
|       |            |          | CT Appointment   |                  |         |
|       |            |          | Day:             |                  |         |
|       |            |          | Date:            |                  |         |
|       |            |          | Time:            |                  |         |
|       |            |          | Ultrasound Appointment |     |         |
|       |            |          | Day:             |                  |         |
|       |            |          | Date:            |                  |         |
|       |            |          | Time:            |                  |         |