PERSONAL HEALTH ASSESSMENT QUESTIONNAIRE

CareATC

*** Fasting is required 8 hours prior to the blood draw. Drink plenty of water & take medications that do not require food.*

FAX: 866.696.7888

Company: **TULSA FRATERNAL ORDER OF POLICE**

1 PERSONAL INFORMATION *(of person being drawn)*

Please use your legal name

SSN Last 4

First Name MI

Last Name

Address

City

State Zip

Date of Birth / /

Gender ☐ Male ☐ Female

Race ☐ Caucasian ☐ African American ☐ Other

2 CONTACT INFORMATION

Home Phone - -

Cell Phone - -

Email

Did you participate last year? ☐ Yes ☐ No

3 PLEASE CHECK ONE OF THE FOLLOWING

☐ A. I am an employee ID #

☐ B. I am a spouse of an employee**

☐ C. I am a dependent of an employee**

***** If either B or C, please provide employee information below.***

First Name MI

Last Name

SSN Last 4

4 MEDICAL AND HISTORICAL INFORMATION *(Optional)*

Note: This information is optional but needed to provide appropriate treatment and care.	Self	Currently Receiving Treatment/Meds	Family History	Hospitalized in the Past 12 mo?
High Blood Pressure	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
Congestive Heart Failure	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Poor Circulation	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Lung Disease (Asthma/COPD)	☐	☐	☐	☐
Obesity/Overweight	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐

Tobacco/Nicotine Use	☐ Yes	☐ No		
Alcohol – Avg. Drinks/Week	☐ None	☐ 1-7	☐ 8-14	☐ More than 14
Exercise – Avg. Hours/Week	☐ None	☐ 1-2.5	☐ More than 2.5	
Sleep – Avg. Hours/Night	☐ Less than 7	☐ 7-8	☐ More than 8	

I give my consent and understand the following:

I hereby authorize CareATC to perform my Personal Health Assessment. I understand that my information will not be shared individually. All results will be shared collectively for reporting purposes and as aggregate health information to provide ongoing wellness support for HIPAA compliant organizations. I further understand that CareATC may contact me regarding my results and that I should follow up with a physician if any findings/concerns arise as part of this health screening.

Signature ____________________ Date ____________

CAREATC STAFF ONLY

Height .

Weight Systolic

Waist . Diastolic

Date / /

Fasting? ☐ Yes ☐ No **STAFF INITIALS:**

PSA? ☐ Yes ☐ No **VITALS:** ______ **COMP:** ______ **DRAW:** ______

Medication? ☐ Yes ☐ No ☐ SN ☐ BF

Notes ____________________

LABCORP CONTROL #