Personal Health Assessment Questionnaire

www.CareATC.com | 4500 S. 129th E. Ave., Suite 191 | Tulsa, OK 74134 | Phone: 800.993.8244 | Fax: 866.696.7888

FASTING IS REQUIRED FOR 12 HOURS PRIOR TO BLOOD DRAW. DRINK PLENTY OF WATER!
Take medication that doesn't require food.

Company: CITY OF EDMOND

1 Personal Information (of person being drawn)

SSN ___ - __ - ____
First Name ____ MI __
Last Name ____
Address ____
City ____
State __ Zip ____
Date of Birth __ / __ / ____
Gender Male M Female F

2 Contact Information

Home Phone ___ - ___ - ____
Work Phone ___ - ___ - ____
Email ____

3 Please Check One of the Following

A) I am an employee. o ID # ____
B) I am a retired employee. o
C) I am a spouse of an employee. o
D) I am a dependent of an employee. o

If either C or D please provide employee information:

First Name ____
Last Name ____
SSN ___ - __ - ____

Are you covered on the employee's health plan? (circle) Y N

4 Medical and Historical Information

	(please circle)	
Did you participate in this Health Assessment last year?	Y	N
Do you use a seatbelt when in an automobile?	Y	N
Do you use tobacco products? (Cigarettes, cigars, snuff or chew)	Y	N
Do you drink two or more alcoholic beverages a day?	Y	N

Are you currently being treated for any of the following? (please circle)

High Blood Pressure	Y	N
Cancer	Y	N
High Cholesterol	Y	N
Diabetes	Y	N
Liver Disease	Y	N
Heart Disease	Y	N
Kidney Disease	Y	N

Male Only

	(please circle)	
Has either parent had a stroke or a heart attack? (Optional)	Y	N
Have you had a Prostate Specific Antigen (PSA) test in the past 12 months?	Y	N
Has anyone in your family had prostate cancer? (Optional)	Y	N

Female Only

	(please circle)	
Has either parent had a stroke or a heart attack? (Optional)	Y	N
Have you had a PAP Smear in the past 12 months?	Y	N
Has anyone in your family had ovarian or breast cancer? (Optional)	Y	N

I give my consent and understand the following:

-By signing below, I hereby authorize CareATC to perform my Personal Health Assessment, including performing a blood test
-None of my Personal Health Assessment data will be shared with my employer.
-My Personal Health Assessment is not, and should not be construed as, a medical diagnosis
-CareATC will review my lab results and other Personal Health Assessment responses. Based on this information, CareATC may contact me. (By Phone and/or Letter)
-Regardless of whether CareATC contacts me, I should contact a physician if I have concerns about my Personal Health Assessment.
-Select information will be shared with a HIPAA compliant organization to provide ongoing wellness support.

Signature ____________________ Date ____________

CareATC Staff Only

Height ___ Systolic ___ Fasting Y N ST1 ____ WT ____
Weight ___ Diastolic ___ Waist ___ New ☐ WM ____ HT ____
Draw Date __ - __ - __ Old ☐ ST2 ____ BP ____
Notes: ### | Meds Taken Y N | PSA ☐ Draw ____ sn bf

Labcorp Control Number