

PLEASE ANSWER THESE ADDITIONAL QUESTIONS

	Yes	No
➤ If you are 50 or older have you had a colonoscopy?	<input type="checkbox"/>	<input type="checkbox"/>
If yes , when was it last done? (month / year)	_____ / _____	
➤ Do you experience leg pains while walking?	<input type="checkbox"/>	<input type="checkbox"/>
➤ Do you snore or quit breathing while sleeping?	<input type="checkbox"/>	<input type="checkbox"/>
➤ Do you feel sleepy or fatigued during the day?	<input type="checkbox"/>	<input type="checkbox"/>

SCREENING RESULTS FOR OFFICIAL USE ONLY

BLOOD PRESSURE _____ / _____ (mmHg)

REQUIRED FOR ALL BLOOD TESTS BELOW: Fasting Non-fasting

TOTAL CHOLESTEROL _____ (mg/dL)

HDL _____ (mg/dL)

LDL _____ (mg/dL)

TRIGLYCERIDES _____ (mg/dL)

BLOOD GLUCOSE _____ (mg/dL)

PSA _____ (ng/mL)

HEEL BONE DENSITY (T-Score) _____ (SD)

BODY FAT _____ (%)

HEIGHT _____ (ft) _____ (in)

WEIGHT _____ (lbs)

HIP _____ (in)

WAIST _____ (in)

VO₂ MAX _____ (ml/kg/min)

GRIP STRENGTH: Sum of both hands _____ kg **OR** lbs

Dominant hand _____ kg **OR** lbs

MUSCULAR ENDURANCE: Push-ups _____ (reps/min)

Curl-ups _____ (reps/min)

Sit-ups _____ (reps/min)

FLEXIBILITY: YMCA Sit and Reach _____ cm **OR** in

ACSM Trunk Flexion _____ cm **OR** in

Improving the health of our community is why we're here! To do this, our health system is working through local employers and other organizations to better understand the healthcare needs of our community.

Now, it's your turn!

The best way for you to improve your individual health is to understand your potential risks. The information you provide will allow us to better understand your personal health needs. Based on your responses, we will be able to recommend specific programs or services designed to reduce your health risks so that you may enjoy a healthier life.

Of course, we will keep confidential the information you provide. After all, it is our hope to improve the lives of our friends, neighbors and colleagues . . . beginning with you!



**NORTON
HEALTHCARE**

CONFIDENTIAL PERSONAL HEALTH PROFILE

GENERAL INFORMATION

(PLEASE PRINT & FILL OUT COMPLETELY)

Employer/Organization _____

Employment Status (Check one) Full-Time Employee Part-Time Employee/Temporary
 Spouse of Employee Self-Employed Retiree

First Name _____ **M.I.** _____

Last Name _____

Home Address _____

City _____ **State** _____ **ZIP** _____

Date of Birth ____ / ____ / ____ **Height** ____ **ft.** ____ **in.** ____ **Weight** ____ **lbs.**

Ethnic Origin (Check one) American Indian/Alaska Native Asian
 Black/African American Hispanic
 Native Hawaiian/Pacific Islander White

Gender Male Female

Marital Status Married Single

Do you have any children age 18 or under? Yes No

If **yes**, what are their ages? _____, _____, _____, _____, _____

Home Phone # _____ - _____ - _____

E-mail Address _____

Preferred Hospital _____
(If you had to choose a local hospital to meet all of your medical needs, which hospital would you choose?)

Health Insurance Provided By: Employer's Plan Medicare Other
 Spouse's Plan Medicaid

Insurance Carrier _____

Insurance Plan Type (Check one) HMO PPO Indemnity/Traditional Other Do Not Know

Is your spouse or family covered by your insurance? Yes No

Do you currently have a Primary Care Physician? Yes No

If **yes**, please provide the name of your physician and the city and state where he or she practices.

Physician's Name *Last:* _____ *First:* _____

City _____ **State** _____

To ensure confidentiality, please provide the last 4 digits of your Soc. Sec. #: _____

HEALTH HISTORY

	Yes	No
➤ Do you smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>
➤ Do you use smokeless tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
➤ Do you have diabetes? If yes , what type do you have? <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	<input type="checkbox"/>	<input type="checkbox"/>
➤ Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
➤ Do you have arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
➤ Have you had your blood pressure checked in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
➤ Have you ever had high blood pressure? If yes , are you treating it with medication?	<input type="checkbox"/>	<input type="checkbox"/>
➤ Have you had your cholesterol checked in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
➤ Have you had your glucose (blood sugar) checked in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
➤ Have you ever had heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
➤ Do you have seasonal allergies?	<input type="checkbox"/>	<input type="checkbox"/>
➤ During the past 12 months, has there been a time lasting two weeks or more that you: Felt sad, blue or depressed?	<input type="checkbox"/>	<input type="checkbox"/>
Lost interest in most things (<i>like hobbies, work or activities that give you pleasure</i>)?	<input type="checkbox"/>	<input type="checkbox"/>

	Never/Rarely	Sometimes	Frequently
➤ How often do you exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ How often do you experience heartburn?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ How often do you experience headaches or migraines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ How often do you wear a seat belt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ How often do you experience high levels of stress?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➤ Have your grandparents, parents, brothers or sisters ever had any of the following diseases? <i>(Check all that apply)</i>			
<input type="checkbox"/> Heart disease (<i>before age 65</i>)	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Cancer	
➤ Have you ever had a physical exam? If yes , when was it last done? (month / year)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ / _____
➤ FOR MEN ONLY: Have you ever had a prostate exam? If yes , when was it last done? (month / year)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ / _____
➤ FOR WOMEN ONLY: Have you ever had a mammogram? If yes , when was it last done? (month / year)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ / _____
➤ FOR WOMEN ONLY: Have you ever had a Pap smear? If yes , when was it last done? (month / year)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ / _____

This information will be kept confidential by the health system and will not be provided to your insurance carrier or sold to any third party. Any information shared with your employer will not identify any single individual and will only represent the workforce as a whole. It is your responsibility to follow up with your physician.

By signing below, you acknowledge that you have been provided a copy of the health system's Notice of Privacy Practices.

X _____ **DATE** _____

The health system cannot accept this information without your signature.