

# Biometric Screening

\_\_\_\_\_  
 Last Name First Name Date of Birth

\_\_\_\_\_  
 Email Phone Number




Gender:  Female  Male      Status:  Employee  Dependent

**Are you fasting?**  Yes  No












This means you have NOT had anything to eat or drink other than water or coffee/tea without sugar or cream in the last 9–12 hours. *Note: If you have not fasted, you may still participate. However, some of your measurements may be affected.*











By signing this form, I attest that all of the above information is accurate to my knowledge. This medical information may be used for treatment, health risk assessment, consultation, billing, claims, payments or other purposes as I may direct.

\_\_\_\_\_  
 Employee/Spouse Signature Date

-  **At Risk:** Consider talking with your primary care provider or specialist.
-  **Elevated:** Changes to diet and exercise can lower your risk of this developing further.
-  **Normal:** Maintain healthy habits.

Height		Weight	% Body Fat
ft	in	lbs	

Total Cholesterol	Triglycerides	HDL Cholesterol	LDL Cholesterol
mg/dL	mg/dL	mg/dL	mg/dL
 > 240 mg/dL	 > 200 mg/dL	 Men: < 40 mg/dL Women: < 50 mg/dL	 > 160 mg/dL
 200–239 mg/dL	 150–199 mg/dL		 130–159 mg/dL
 < 200 mg/dL	 < 149 mg/dL	 Men: > 40 mg/dL Women: > 50 mg/dL	 < 100 mg/dL <i>&lt; 70 if coronary artery disease is present</i>

Glucose (mg/dL)	Resting Heart Rate	Waist	Blood Pressure	
mg/dL	beats/min	in	Systolic	Diastolic
 ≥ 126 mg/dL	 > 100 beats/min	 Men: > 40 in Women: > 35 in	 > 129	> 120
 100–125 mg/dL			 120–129	80–119
 < 100 mg/dL	 60–100 beats/min	 Men: < 40 in Women: < 35 in	 < 120	< 80

Please fax completed form to Memorial Choice at 217-527-3435 or email to MemorialChoice@mhsil.com.

Last Name	First Name
-----------	------------

**FOR OFFICE USE ONLY**

Health Risk Assessment complete?  Yes  No

Facility Name

Provider Signature	Date
--------------------	------

**Wellness Recommendations**

Handouts provided:  
 Glucose/A1c  Blood Pressure  Cholesterol  Other:

<input type="radio"/> Work with primary medical provider	<input type="radio"/> Follow-up from Health Coach	<input type="radio"/> Follow-up declined
<input type="radio"/> Work with Wellness provider	<input type="radio"/> Recheck in:	
<input type="radio"/> EAP	<input type="radio"/> No follow-up recommended	

Goal: