*THE FOLLOWING TO **BE** COMPLE**TED BY** HEALTH EXAMI**NER AT** A **HEALTH SCR**EENING EVENT*

HEALTH RISK QUESTIONNAIRE (HRA) BIOMETRICS RECORD

Healics
With you for life

Fill check-boxes completely with BLACK pen *ONLY*

A	B	C	7	8	9

Please print, using numbers and UPPERCASE LETTERS only

Screening Date (MM/DD/YYYY)

Participant Name

Last Name | First Name | Mid Init

DOB | Was a blood sample taken? YES NO | If no, reason | Hours fasted

WOMEN ONLY: Are you pregnant? YES NO

INSTRUCTION TO EXAMINER: if pregnant, do not measure weight or waist

Height (without shoes) feet inches | Weight (fully clothed without shoes) PREGNANT WOMEN: Pre-pregnancy weight

MEN & WOMEN: Inches around waist at navel (over clothes, to nearest ½") inches

Blood Pressure	/	
Repeat blood pressure if 140/90 or higher	/	
Repeat blood pressure if 160/100 or higher	/	
Optional	/	

EXAMINER NAME

HRA PARTICIPANT: By initialing here, I am indicating that the blood pressures, height, weight, and waist measurements recorded by the examiner are accurate. Please initial here →→

EXAMINER NOTES

INSTRUCTIONS TO EXAMINER: Following the health screen, send completed questionnaires with cover sheet in a TRACKABLE method to Healics, Inc., 8919 W. Heather Ave., Milwaukee, WI 53224

bellin health

HEALTH SCREENING PROGRAM CONSENT AND AUTHORIZATION

Barcode

The purpose of this voluntary health screen program offered through your employer is to gather sufficient information about you so you can receive an informative Healics, Inc. Health Risk Assessment (HRA) Report. The report you will receive and the medical information shared among Bellin Health, Healics, Inc., and the lab will constitute protected health information as defined by the privacy regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Rule). Bellin Heath and Healics, Inc. have executed confidentiality agreements and certifications as necessary to comply with the HIPAA Privacy Rule.

Name of Employer Sponsoring HRA: _____

Last Four Digits of Your Social Security Number (SSN*): XXX-XX-_____ Have you completed a Healics health risk assessment before? ( ) Yes ( ) No

**SSNs are kept confidential and used by Healics and the lab for identification purposes only and will not be used for report scorecards or mailings.*

Name (please print): _____ (Last Name) _____ (First Name) ____ (Middle Initial)

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: ( ) _____ ( ) Mobile ( ) Work ( ) Home

E-mail _____ Best Way to Reach You: ( ) Phone Call ( ) Text ( ) E-mail

Gender: ( ) Male ( ) Female Date of Birth (Month/Day/Year): _____/_____/_____ Age: _____

Regarding the sponsor employer, are you the: ( ) employee ( ) employee's spouse ( ) retiree ( ) retiree's spouse ( ) other

CONSENT TO HEALTH RISK ASESSMENT BLOOD TESTS: I wish to participate in a voluntary Health Risk Assessment (HRA) program sponsored by my employer or by my spouse's employer (the sponsoring employer). As part of that program, I hereby provide my consent to Bellin Health (and any provider working with Bellin Health on the HRA program, including, but not limited to, Healics, Inc., and/or Clinical Reference Lab) to take measurements, including my blood pressure, to draw blood samples from my arm and to analyze the blood sample and test results. I understand there are possible risks associated with taking blood pressure or drawing blood from my arm including, but not limited to, the risk of infection, discomfort and bruising. I understand that other, more remote risks may be involved, however the information I have received is sufficient for me to consent to the blood sample, testing, and analysis. The screening vendor is not responsible for such conditions or effects (for example, the screening vendor will not pay for a physician to visit to treat bruising). I understand that 1) the results from my blood test are preliminary only and do not mean I have a particular diagnosis, 2) the HRA is not intended to replace a full examination by my own physician, and 3) I am responsible, if I choose, for sending copies of my HRA results to my personal physician and arranging any follow-up examination(s) deemed necessary by my physician. I understand that the blood test results will be entered into and available through the Bellin Health electronic medical record system. I have read/had read to me the above. I have had the chance to talk about any questions and concerns, which were answered to my satisfaction. I understand and agree with the above. Dr. Mark Ringwelski will be the ordering provider for HRA lab tests.

Signature of HRA Participant date/time Signature of Witness date/time

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH RISK ASSESSMENT INFORMATION: I understand that Bellin Health will be obtaining personal health information (PHI) from me as part of my voluntary participation in the Health Risk Assessment, including, but not limited to, the results of the measurements, blood pressure tests, and blood tests, and the information on my health questionnaire that I will be providing as part of the HRA process. I hereby authorize that all such information relating my Health Risk Assessment, including my PHI, may be used by Bellin Health (and the other HRA providers, such as Healics or Clinical Reference Lab, working with Bellin Health) to perform the HRA. I authorize such information to be disclosed by those parties to those vendors, including Healics, retained by Bellin Health or the sponsoring employer to process my Health Risk Assessment and HRA reports and/or to provide health management services connected to the HRA Program. I understand that Bellin Health and all the vendors involved in the HRA and health management process are required to maintain the privacy of my PHI except as I may specifically authorize. I authorize the release of my name as an HRA participant to the sponsoring employer for the purpose of creating a participant name list. In the event that the sponsoring employer offers an incentive or health management program related to the HRA lab values, scores, and/or nicotine results, I authorize the release of my lab values, scores, and/or nicotine results to the sponsoring employer or its designated agent to use in the incentive or health management program. I understand that no other PHI or other information resulting from the Health Risk Assessment will be shared with the sponsoring employer or with any other party not specifically authorized under this agreement. I understand the program including any possible consultation or follow-up is not a substitute for a full examination by my own physician. I accept responsibility for arranging any follow-up examinations that may be appropriate. I authorize Bellin Health to use my PHI for payment and health care operations and to send me targeted information, based upon my personal health profile, designed to assist me in lowering my health risks and accessing necessary health care services. I am agreeing that I have read, understand, and am voluntarily agreeing to all the terms outlined on this page and that no strikeouts or additional writing will be accepted on this authorization. I have had the opportunity to raise any questions or concerns with Bellin Health, or other HRA provider, which were answered to my satisfaction. I further agree, understand, and acknowledge the following:

- That this Authorization is meant to comply with all state and federal laws regulating the form and content of authorizations for disclosure of medical information, including but not limited to, the medical privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA).
- That I have a right to request access to all my medical records that are used or disclosed pursuant to this Authorization
- That a photocopy of this Authorization will be as valid as the original.
- That I may request a copy of this Authorization.
- That I may refuse to sign this Authorization. Refusal to sign the authorization means that I am no longer eligible to participate in the assessment process.
- That this authorization will stay in effect until revoked or superceded by another agreement.
- That I may revoke this authorization at any time in writing, I understand that the revocation will not affect actions taken by parties in reliance on this Authorization.
- That my rights to revoke may also be limited by any Notice of Privacy Practices provided to me by my health care providers pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations.
- That I may contact the Bellin Health Privacy Offices at (920) 433-3595 for information on how to revoke my authorization,
- That disclosed PHI may be subject to redisclosure by the person receiving the PHI and privacy protections may be lost.
- That the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits (except as has been explained to me by the sponsoring employer) on my decision to sign this authorization.
- That I have been provided with a copy of Bellins Health's Notice of Privacy Practices.

I have read/had read to me the above. I have had the chance to talk about any questions and concerns, which were answered to my satisfaction. I understand and agree with the above.

Signature of HRA Participant date/time Signature of Witness date/time

Please answer the questions on the following pages. Bring the completed questionnaire to the health screening. If your doctor has prescribed any medication, you must stay on that medication for the health screen. Fax all pages of this questionnaire after completion to (920) 436-8699, ATTN: Screen Team

Information will be stored on the Healics, Inc. Computer System

1 MEDICAL HISTORY

Have you ever been diagnosed or treated for any of the following conditions?	Yes	Are you taking prescription medication for this condition? (check box if yes)
Allergies	☐	☐ al
Asthma	☐	☐ as
Chronic lung disease	☐	☐ ln
Diabetes	☐	☐ db
Fibromyalgia	☐	☐ fi
Heartburn/acid reflux	☐	☐ hb
Heart attack	☐	☐ ha
Heart conditions/problems	☐	☐ he
Irritable Bowel Syndrome/Crohn's	☐	☐ ib
Kidney disease	☐	☐ kd
Liver disease	☐	☐ lv
Lymes disease	☐	☐ ly
Sleep disorder/trouble sleeping	☐	☐ sl
Stroke	☐	☐ st
Thyroid disease	☐	☐ th
Other condition(s)	☐	☐ ot
None of the above	☐	no

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Have you ever been diagnosed or treated for any of the following conditions?			
Cholesterol problems	☐	☐	ch
High blood pressure	☐	☐	bp
Obesity (overweight)	☐	☐	wt
None of the above	☐		no

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Have you ever been diagnosed or treated for any of the following conditions?			
Arthritis	☐	☐	ar
Back or neck pain/problems	☐	☐	ba
Cancer	☐	☐	cn
Depression/Anxiety	☐	☐	dp
Migraine headache	☐	☐	mg
None of the above	☐		no

4 PREGNANCY (Females only)

	No	Yes
Are you pregnant?	O	O
Are you post-partum (0-6 months)?	O	O

Trimester	1st	2nd	3rd
	O	O	O

Pre Pregnancy Weight: ___

Delivery Date (MM/DD/YYYY): ___

5 WEEKLY EXERCISE

On average, how many hours per week do you exercise (excluding work activity), in which your rate of breathing and heart rate increases for a total of 20 minutes or longer?

3+ hours	2 to 3 hours	1 to 2 hours	½ to 1 hour	Less than ½ hr
O	O	O	O	O

6 ERGONOMICS

On average, how many hours per day do you spend...

	9+ hours	6-9 hrs	3-6 hrs	Less than 3 hrs
Sitting?	O	O	O	O
Standing?	O	O	O	O
Performing repetitive motions?	O	O	O	O

7 SLEEP

On average, how many hours a day do you sleep?	9+ hours	6-9 hrs	3-6 hrs	Less than 3hrs
	O	O	O	O

	No	Yes
Do you experience interrupted sleep, sleep apnea, difficulty with quality sleep?	O	O

8 NICOTINE

Have you ever used products containing nicotine?

- No O
- I did, but quit O — Quit Date (MM/DD/YYYY): ___
- Current nicotine user O

I currently use nicotine in the following way(s):

- ☐ Cigarettes
- ☐ Cigars
- ☐ Pipe
- ☐ Chew/dip/pouches
- ☐ Nicotine replacement therapy (gum/patch/lozenge)
- ☐ Electronic cigarettes (vaping)

9 ALCOHOL

Do you normally have at least 1 or more beverages containing alcohol each week?

No	Yes
O	O

If yes, what is the highest average number of beverages containing alcohol per day?

1	2	3	4	5+
O	O	O	O	O

If yes, what is your average number of beverages containing alcohol per week?

1-7	8-14	15-21	22-28	29+
O	O	O	O	O

10 SAFETY

How often do you wear seat belts when you drive/ride in a vehicle?

O Always O Usually O Frequently O Occasionally O Never

11 STRESS

Indicate how often the following apply to you:

	Always	Usually	Sometimes	Never
I feel stress from work issues	O	O	O	O
I feel stress from family/personal relationships	O	O	O	O
I feel stress from financial concerns/issues	O	O	O	O
I feel stress from health concerns/issues	O	O	O	O

12 WORKSITE PRODUCTIVITY

In the past four weeks, how often did the following keep you from working all or most of the day?

	Always	Usually	Sometimes	Never
Illness	O	O	O	O
Injury	O	O	O	O
Emotional Problems	O	O	O	O

13 READINESS TO CHANGE

How would you like to enhance or improve your quality of life? Please rate your readiness to change:

① I don't have a concern, I'm doing well in this area.
② I've begun making a positive change in the area, but need to maintain
③ I'm ready to start and want more information (used for program planning by your employer)
④ I would like to start, but concerns are holding me back.
⑤ I have a problem but I am not ready to make a positive change.

Nicotine Use	① ② ③ ④ ⑤
Alcohol Use	① ② ③ ④ ⑤
Exercise Habits	① ② ③ ④ ⑤
Eating Habits	① ② ③ ④ ⑤
Stress Management	① ② ③ ④ ⑤
Weight Management	① ② ③ ④ ⑤

14 INTEREST SURVEY

Choose three wellness topics of interest to you (used for program planning by your employer).

☐ Alcohol/drug education	☐ Back/neck health	☐ Blood pressure
☐ Cancer risk reduction	☐ Cardiovascular exercise	☐ Cholesterol
☐ Financial wellness	☐ First aid/CPR	☐ Workplace programs/seminars
☐ Medical self-care	☐ Men's health	☐ Nutrition
☐ Nicotine cessation	☐ Stress management	☐ Weight control
☐ Women's health	☐ None of the above	

15 PRIMARY CARE PROVIDER

	No	Yes		No	Yes
Do you have a Primary Care Provider?	O	O	Have you had an annual physical with your Primary Care Provider in the last 12 months?	O	O

16 SELF-REPORTED HEALTH MEASUREMENTS

Height: ___ feet ___ inches Weight: ___ pounds

Thank you for completing your Health Risk Questionnaire!
Please bring it with you to your screening, and remember to fast and drink water per participant instructions. Follow your examiner's instructions after your blood draw.