

MEMBER NAME:	EMPLOYER:
ADDRESS:	PHONE NUMBER:
DATE OF BIRTH:	EMAIL ADDRESS:

Blood Work Fasting? Yes / No

Gender: __Male __Female

Female-Currently Pregnant: __ Yes __No

Health Measure:	Date	Results:	Exceptions:
Current Smoker		___ YES ___ NO	
Smoking Cessation Counseling		___ Completed ___ Declined	
BMI Waist Circumference (optional)		Height = _____ Inches Weight = _____ Pounds _____ Inches	If pregnant use pre-pregnancy information
Blood Pressure		_____ mmHg	___ Taking blood pressure medication
Fasting Total Cholesterol HDL: LDL: Triglycerides:		_____ mg/dl _____ mg/dl _____ mg/dl _____ mg/dl Ratio ____ : ____	
Glucose HbA1c (optional – physician’s discretion)		Fasting Blood Sugar: _____ mg/dl _____ %	___ Diagnosed Diabetic

HEALTH SCREENINGS	COUNSELING	IMMUNIZATIONS	COUNSELING
<input type="checkbox"/> Prostate	___Yes ___No ___Declined	<input type="checkbox"/> Flu	___Yes ___No ___Declined
<input type="checkbox"/> Breast Cancer	___Yes ___No ___Declined	<input type="checkbox"/> Pneumococcal Vaccine	___Yes ___No ___Declined
<input type="checkbox"/> Cervical Cancer	___Yes ___No ___Declined	<input type="checkbox"/> Pertussis Update	___Yes ___No ___Declined
<input type="checkbox"/> Colorectal Cancer	___Yes ___No ___Declined	<input type="checkbox"/> Shingles	___Yes ___No ___Declined
<input type="checkbox"/> Skin Cancer	___Yes ___No ___Declined	<input type="checkbox"/> HPV Vaccine	___Yes ___No ___Declined

Health Practitioner Signature or Office Stamp: _____ Date: _____

Health Practitioners Phone Number: _____

All information will be kept confidential within the Wellness Program and specific results of an individual will not be shared. Information will be included in the individuals Health Action Report provided at the completion of the Personal Health Profile. The submission of this completed form will be noted and that information used to towards the administration of incentive reward.

Permission to Release this completed form to the Wellness Office at Empire State Highway Contractors Assn, Inc. Please fax it to the attention of the Wellness Coordinator at 315-895-5307

Members Signature: _____ Date: _____

Steps:

- 1) Make your appointment to complete your Annual Physical Exam (include blood work).
 - a. Give this form to your doctor for completion.
 - b. Once complete: mail, email (good cell phone picture) or fax to:

Mail: Empire State Highway Contractors Association
Wellness Coordinator
2481 Higby Road
Frankfort, NY 13340

Fax: 315-895-5307

E-mail: pflaherty@eshca.org

- 2) This exam is covered by your ESHCA insurance once within the calendar year (\$0 copay). **Be sure to take your medication list so you can re-evaluate your medications and dosages with your doctor.**
- 3) If you have already completed your exam for the current year, drop this form off to your doctor's office for completion. Either make-arrangements to pick it up or have them send it in on your behalf.

Follow the 3 Steps to Receive the \$200 Incentive:

- 1) Submit the General Health Assessment (www.eshca.org or call/email me)
- 2) Submit MD Biometric Form
- 3) Submit MVP Explanation of Benefits (receipt from MVP) \$200

Questions or comments contact:

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Fax: 315-895-5307
pflaherty@eshca.org

Website: www.eshca.org