



Health Screening Provider Use Only	
<input type="checkbox"/> HTN	<input type="checkbox"/> MTM
HRA Complete <input type="checkbox"/> Yes <input type="checkbox"/> No	

**IMPORTANT NOTICE: Please provide your WSU OneCard when you present this form.**

First Name: \_\_\_\_\_  
 Last Name: \_\_\_\_\_  
 Access ID: \_\_\_\_\_ Banner ID: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female

Preferred Contact Phone Number: (\_\_\_\_) \_\_\_\_\_  
 May we leave you a message at this number?  Yes  No

Preferred Contact Email: \_\_\_\_\_  
 May we send result information to this email address?  Yes  No

Please list the prescription medications you currently take:

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Please list the over-the-counter medications/supplements you take:

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Do you smoke?  Yes  No  
 Are you pregnant?  Yes  No  
 Do you have dietary restrictions?  Yes  No  
 Do you exercise regularly?  Yes  No  
 Have you taken the online Health Risk Appraisal?  Yes  No  
 Have you had any food or drink, except water, in the last 9-12 hours?  
 Yes  No  
 Has anyone in your immediate family (mother, father, sibling) had  
 cardiovascular disease (heart attack or stroke)  Yes  No  
 If yes, who and at what age? \_\_\_\_\_

Please check all the conditions that apply to you:

- High Blood Pressure  Stroke  Coronary Disease  
 High Cholesterol  Diabetes  Bypass Surgery  
 Angioplasty  Kidney Disease  Angina (chest pain)  
 Peripheral Artery Disease  Heart Attack

**TESTING CONSENT**

I am requesting to receive a biometric health screening to be administered by the appropriate personnel designated by University Pharmacy and Wayne State University College of Pharmacy and Health Sciences. I hereby consent to the administration of the test to me. In signing this consent, I verify the following:

- I have read and understand all the terms of this consent. I agree to all of its terms and execute it to my own free will.
- I have chosen, of my own free will, to receive and participate in the test.
- I have received a copy of and understand the University Pharmacy Notice of Privacy Practices.

I understand and agree that this test and the results therefrom are not meant to be a substitution for consultation with or advice from my physician. I understand that I may receive results that may be considered "abnormal" as well as an explanation of these results. However, I also understand that screening tests can give false positive or negative results for a variety of reasons. I further understand and agree that it is my obligation to arrange a follow-up consultation with my physician to review the test results and discuss the appropriate course of action.

I hereby release University Pharmacy, Wayne State University and Wayne State University College of Pharmacy and Health Sciences, Ulliance and their representatives and agents from and against any and all liability for damages or injuries resulting from my failure to follow-up with my physician regarding the test results.

**RESULTS**

Ht. \_\_\_\_ ft. \_\_\_\_ in.  
 Wt: \_\_\_\_ lbs. BMI: \_\_\_\_  
 Waist: \_\_\_\_ in.  
 BP: Systolic: \_\_\_\_\_  
 Diastolic: \_\_\_\_\_  
 10-yr Risk Score: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

Your Initial Ulliance Wellness Coaching Session - Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_

<http://wsu.lifeadvisorwellness.com>