Please check all the conditions that apply to you:

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

Please list your medications:

<table>
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<tr>
<th>Prescribed</th>
<th>Over the Counter / Supplements</th>
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Initial________ I authorize and consent to diagnostic testing at Campus Health Center (“Center”). I understand that the practice of medicine is not an exact science, and no guarantees or promises have been made concerning the outcome of any testing. I have the right to make decisions concerning my health care, including my right to refuse any testing. If any agent or employee of the Center AT ANY TIME sustains a percutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound or other significant exposure to my blood or other bodily fluids, I may be tested for HIV (the virus that causes AIDS), Hepatitis B, Hepatitis C, and/or Syphilis, and I consent to such tests.

Initial________ I reviewed the Center’s Notice of Privacy Practices that contains information about how, why and when the Center may use and disclose Protected Health Information (“PHI”), as defined by HIPAA. I acknowledge that Center may, from time to time, change its privacy practices and agree that it may use and disclose my PHI in accordance with its Notice of Privacy Practices and the authorization provided below.

Initial________ I authorize Center to disclose my PHI to Ulliance, Inc., an organization selected by Wayne State University in connection with the Wellness Warriors program. I understand and agree that (i) authorizing the disclosure of PHI is voluntary and that it covers multiple requests for and disclosures of PHI, (ii) I may refuse to authorize disclosure of my PHI, and Center may not condition treatment or eligibility for benefits on whether I provide this authorization, (iii) Ulliance, Inc. was informed that further use and disclosure of PHI must be consistent with the authorized purpose for which it was released, but that any disclosure of PHI carries with it the potential for an unauthorized re-disclosure and it may not be protected by federal or state privacy rules, (iv) Ulliance, Inc. and Center are independent service providers and are not affiliated, (v) I may revoke this authorization at any time in writing, but revocation will have no impact on disclosures of PHI made while this authorization was valid, (vi) this authorization shall expire one (1) year after the date listed below, (vii) if I refuse to provide this authorization or revoke it, Center may not be able to release PHI to Ulliance, Inc. and is not responsible for any consequences of same or to notify me of any such consequences, and (viii) I have received a copy of this signed form.

Initial________ I certify that all information provided by me on this form is true and correct, that I fully understand the consents and authorizations given above, that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily, and that I am the Patient listed in this document or I am duly authorized by the Patient to provide the consents and authorizations herein and to sign this document.

Initial________

Signature: ____________________________ Date: ___________ MM / DD / YY

Office Use Only: Screener: ________________________________ Screening Date: ________________

Waist: _______ total inches
Ht.: _______ total inches
Wt.: _______ lb
BMI: _______
BP: Systolic ________
Diastolic ________

Are you Fasting: ☐ Yes ☐ No
Do you Smoke: ☐ Yes ☐ No