HealthAdvocate™
Always at your side

Physician
Health Screening Form

(Please Print)

Last Name: ______________________ **First Name:** ______________________

Company: ______________________ **Zip Code:** __________ **Employee ID#:** ______________ (optional)

Choose One: Employee ☐ Spouse ☐ Domestic Partner ☐ **Current Age:** ______________

Last 4 SS#: ______________ **DOB:** ______ ______ ______ (Month) (Day) (Year) **Gender:** Male ☐ Female ☐

Date of Hire: ___/___/___ **Email Address:** ______________________ **Phone:** ______________

If for spouse or domestic partner, please list employee's name: ______________________

I authorize my healthcare provider to release the requested information to Health Advocate, Inc.

Signature: ______________________ **Date:** ______________

Do not write below this line

To Be Completed by Physician Office

Please enter the results of the physical below and attach a copy of the lab work.

Height: ________ FEET ________ INCHES

Weight: ________._____ POUNDS

Waist: ________._____ INCHES

Total Chol: ________

HDL: ________

Trig: ________ LDL: ________

Ratio: _____._____

Glucose Fasting: ________

OR Glucose Non-Fasting: ________

OR HbA1c: ________._____

Blood Pressure: ______/______

______/______/______ **DATE OF EXAM** **Patient Pregnant:** **Yes** ☐ **No** ☐

Healthcare Provider Signature ______________________ Office Telephone Number ______________________ Signature Date ______________________

After providing any needed counseling on values obtained, please fax the results to Health Advocate at 610.397.7891. MUST BE FAXED FROM PHYSICIAN'S OFFICE.

Results may be verified with physician's office.

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