Health Risk Questionnaire

The purpose of this voluntary health screen program offered through your employer is to gather sufficient information about you so that 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 Health and Healics, Inc., have executed confidentiality agreements and certifications as necessary to comply with the HIPAA Privacy Rule.

Name of Employer Sponsoring HRA: _____

Your Social Security Number: _____ Have you done a Healics Health Risk assessment before? ( ) Yes ( ) No

** SSN is kept confidential and is used by Healics and the lab for identification purposes only and will not show up on any HRA scorecards or mailings.

Name (please print): _____ _____ _____

Last Name *First Name* *Middle Initial*

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: ( ) _____ Work Phone Number: ( ) _____

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

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

CONSENT TO HEALTH RISK ASSESSMENT 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 the 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.

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 to 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 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 and 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 the 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 the authorized 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 Officer 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 Bellin 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 screen.

Fax both sides of this questionnaire after completion to (920) 436-8699, ATTN: Screen Team

Questionnaire Page Two

Participant Name: _____

1. **Immediate family history:** Question removed due to new Federal Regulations regarding collection of family history data.
2. **Your personal history:** Have you had any of the following?
   ( ) Asthma ( ) Chronic lung disease, bronchitis, or emphysema
   ( ) Diabetes ( ) Congestive heart failure, heart failure, weak heart
   ( ) Stroke ( ) Coronary artery disease, angina, chest pain
   ( ) Allergies/hay fever ( ) Heart attack ( ) Chronic heart burn
   ( ) Heart disease ( ) Kidney disease ( ) Liver disease
   ( ) Thyroid disease ( ) Fibromyalgia ( ) None of these
3. **Cardiovascular Risks:** Did a doctor ever tell you that you had?
   ( ) High blood pressure ( ) High cholesterol
   ( ) Obesity (overweight) ( ) High Chol/HDL ratio ( ) None of these
4. **In the last six months have you been diagnosed with or treated for any of the following:**
   ( ) Back pain ( ) Cancer, not skin
   ( ) Depression ( ) Migraine headaches
   ( ) Osteoarthritis ( ) Rheumatoid arthritis ( ) None of these
5. **Current Medications:** Do you take prescription medicine for?
   ( ) Arthritis ( ) Asthma, incl. inhaler ( ) Blood pressure
   ( ) Cholesterol ( ) Depression ( ) Digestive probs
   ( ) Heart problems ( ) Diabetes ( ) Lung/respiratory
   ( ) Sleeping ( ) Stress/Anxiety ( ) Thyroid
   ( ) Weight ( ) Other ( ) None
   How many meds do you take a day? (Enter zero if none) _____
   If on meds, how often do you take according to directions?
   ( ) 100% ( ) 75% ( ) 50% ( ) 25% ( ) Never
6. **If female, are you pregnant?**
   ( ) no ( ) yes, pre-pregnant weight _____ ( ) I don't know
   If yes, which term: ( ) 1st ( ) 2nd ( ) 3rd
   Are you 0-6 months post-partum? ( ) no ( ) yes
   If yes, delivery date _____
7. **Tobacco Use:**
   Have you ever smoked, chewed tobacco or used snuff?
   ( ) No, I have never used tobacco
   ( ) I did, but I don't now and I quit _____/_____/_____ (mo/da/yr)
   ( ) Yes, I currently use tobacco.
   I currently use: ( ) Cigarettes ( ) Cigars ( ) Pipe ( ) Other
   If yes, number per day _____ or per week _____
8. **Vehicle Safety:** How often do you wear seat belts when driving/riding in a vehicle?
   ( ) Always ( ) Usually ( ) Frequently ( ) Occasionally
   ( ) Never
9. **Alcohol Use:** Do you normally have at least 1 or more beers, glasses of wine, or mixed drinks each week? ( ) No ( ) Yes
   If yes, what is the highest number of drinks any given day?
   ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5+
   If yes, what is the average number of drinks per week?
   ( ) 1-7 ( ) 8-14 ( ) 15-21 ( ) 22-28 ( ) 29+
10. **Weekly Exercise:** How much weekly-sustained moderate exercise such as walking, swimming, dancing, bicycling, jogging, exercise machine, or equivalent, now and for last six months.
    ( ) More than 3 hours ( ) 2 to 3 hours ( ) 1 to 2 hours
    ( ) ½ to 1 hour ( ) Less than ½ hour
11. **Readiness to change**: Please rate the 6 health habits below by using the following table.
    ① I don't have a problem; I'm doing well in this area.
    ② I've begun making a positive change, but need to maintain.
    ③ I'm ready to start and want more information.
    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.

1. Tobacco use: How do you feel about quitting?	①	②	③	④	⑤
2. Alcohol use: How do you feel about quitting?	①	②	③	④	⑤
3. Exercise: How do you feel about improving?	①	②	③	④	⑤
4. Eating habits: How do you feel about improving?	①	②	③	④	⑤
5. Stress: How do you feel about improving?	①	②	③	④	⑤
6. Weight: How ready are you to lose permanently?	①	②	③	④	⑤

12. **Interest Survey**: Please check up to three wellness programs that interest you enough that you'd attend in the near future.
    ( ) Aerobics to music ( ) Alcohol/drug educ. ( ) CPR
    ( ) Stress management ( ) First aid ( ) Men's health
    ( ) Blood pressure educ. ( ) Healthy back ( ) Stop smoking
    ( ) Cancer risk reduction ( ) Lunch seminars ( ) Walking group
    ( ) Cholesterol reduction ( ) Medical self care ( ) Weight control
    ( ) Nutrition educ. ( ) Women's health ( ) None of these
13. **Self-reported health measurements**:
    Height: _____ feet _____ inches Weight: _____

HEALTH MEASUREMENTS

The following to be completed by health examiner at a health screen.

Blood Sample: ( ) Yes ( ) No If yes, hours fasted _____
If no blood sample, what was the reason?
_____

Optional Test:

____ PSA _____ Initials (If optional, I agree to pay for the cost of the test.)
____ Refused PSA _____ Initials

1. Height without shoes: _____ feet _____ inches
2. Fully clothed weight without shoes: _____ pounds
3. Inches around wrist between wrist bone and hand to nearest ¼" _____
   Inches around waist at belly button in indoor clothes to nearest ¼" _____
   WOMEN: Inches around hips at widest in clothes to nearest ¼" _____
4. Blood pressure: _____/_____
   (repeat if 140/90) _____/_____

Name of examiner: _____

Date of health screen: _____

Participant: By initialing here, I am indicating that the weight, waist, and hip measurements recorded by the examiner are accurate: _____ Initials

Instructions to Examiner: Following the health screen, send completed questionnaires with cover sheet in a TRACKABLE method to:
Bellin Health Screen Team, 905 Cass Street, Green Bay, WI 54301-3510 or fax to (920) 436-8699, ATTN: Screen Team
Information will be stored on the Healics Health Information Computer System.