



## Onsite Biometric Screening Event Form

### Personal Information (Participant completes PRIOR to the screening):

Name: \_\_\_\_\_ Company: \_\_\_\_\_  
 Work Location: \_\_\_\_\_ Department: \_\_\_\_\_ Shift: \_\_\_\_\_  
 Select One:  Employee  Dependent Employee Name (If Dependent): \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_' \_\_\_\_\_" Race: \_\_\_\_\_  
 Gender:  Male  Female Email: \_\_\_\_\_  
 Employee ID: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

### Participant Questionnaire (Participant completes PRIOR to the screening):

Are you interested in participating in a company sponsored health coaching program? \_\_\_Yes \_\_\_No  
 Do you have a primary care provider? \_\_\_Yes \_\_\_No  
 What was the year of your last primary care visit? \_\_\_\_\_  
 Are you current with all age and disease specific vaccines (including annual flu)? \_\_\_ Unsure \_\_\_Yes \_\_\_No  
 Have you used any tobacco or nicotine products in the past 30 days? \_\_\_Yes \_\_\_No  
 If you use tobacco or nicotine products, what type do you use? \_\_\_ Vape \_\_\_Smoke \_\_\_Chew  
 If you smoke cigarettes, on average how many cigarettes do you smoke per day? \_\_\_\_\_  
 If you use tobacco or nicotine products, are you interested in quitting? \_\_\_ Unsure \_\_\_Yes \_\_\_No  
 On average, how many hours do you sleep per night? \_\_\_\_\_  
 On average, rate your stress level on a scale of 1 to 10 (1 = low stress to 10 = extreme stress). \_\_\_\_\_  
 On average, how many days per week do you exercise for at least 30 minutes? \_\_\_\_\_  
 On average, how many processed or sugar sweetened beverages or snacks do you consume daily? \_\_\_\_\_  
 On average, how many times per week do you eat out or get take-out food? \_\_\_\_\_  
 On average, how many fruit or non-starchy vegetable servings do you eat per day? \_\_\_\_\_  
 On average, how many 8 oz. glasses of water do you consume per day? \_\_\_\_\_  
 On average, how many alcoholic drinks do you consume in a week? \_\_\_\_\_  
 In an average week, what is the maximum number of alcoholic drinks you consume in a day? \_\_\_\_\_  
 How many medications do you take daily? Rx \_\_\_ OTC \_\_\_  
 On average, how many medication doses do you miss per week? \_\_\_\_\_  
 Please place a check mark to the left of any condition(s) for which you currently take at least one medication:  
 \_\_\_ Asthma/COPD \_\_\_ Blood Pressure \_\_\_ Cholesterol \_\_\_ Depression/Anxiety \_\_\_ Diabetes

**My submission of this form confirms that I agree to all the terms and conditions of Triad Care's Biometric Screening Consent Form and attest to the accuracy of the information provided above.**

### Biometric Results (Provider completes DURING the screening):

BP (Manual BP ≥140/90)		Total Cholesterol		Height	
Pulse		HDL		Weight	
Manual BP (MD ≥160/90)		TRG (MD ≥400)		Waist Circumference	
A1C (MD ≥6.5%)		Glucose (MD ≥126/200)		Hip Circumference	
Cotinine <input type="checkbox"/> Positive <input type="checkbox"/> Negative		LDL (MD ≥160)		Body Fat %	
CardioChek Time:		Fasting ≥ 12 hours <input type="checkbox"/> Yes <input type="checkbox"/> No		BMI (MD >35)	

Notes:

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Follow-up needed?  Yes  No