

Physician Health Screening Form

*Your patient is taking part in Healthy OHIO- Ohio University's wellness initiative. He/she needs the measurements and fasting lab values below in order to complete a Personal Wellness Profile™. Values are only valid if performed **within the last three months**. Please fill in any lab values that you have and return to your patient. Thank you for your assistance.*

Date lab values/measurements taken: ____/____/____

Frame Size: _____

Height: _____

Weight: _____

Waist Girth: _____

Hip Girth: _____

Body Fat Percentage: _____

Blood Glucose: _____

Total Cholesterol: _____

High Density Lipoprotein (HDL): _____

Low Density Lipoprotein (LDL): _____

Triglycerides: _____

Blood Pressure: _____

HbA1c: _____

Health Care Professional's Signature

Date

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