Cleveland Clinic | Healthy**Choice**

Health Visit Form

All sections of this form must be completed and signed by a licensed health professional (MD, DO, NP, PA) from your PCP's office and mailed, emailed, or faxed directly to EHP.

DATE OF EXAM (required)

PROVIDER INFORMATION

Last name: ______________________________

First name: ______________________________ Middle initial: ________

Office: ______________________________

Address: ______________________________

Telephone: (________) ______________________________

PATIENT INFORMATION (required)

Last name: ____________________ First name: ____________________ Middle initial: _____

EHP ID: ____________________ Date of birth: ____________________

BIOMETRIC DATA (required)

Height: __________ Weight: __________ BMI: __________ Blood pressure: __________

LAB WORK (required)

If under age 40, all individuals should have a baseline panel. If normal, repeat at age 40. For age 40 or older, cholesterol screening must be within last three years.

Date drawn: ____________________ LDL: __________ LDL:HDL ratio: __________

CHRONIC CONDITIONS (required)

Check Yes if patient has diagnosis. Check No if screen is negative or there is no patient history

Hypertension	❑ YES	❑ NO	Check Yes if BP > 140/90 or on treatment regimen
Diabetes	❑ YES	❑ NO	Check *(if applicable):* ❑ Type 1 ❑ Type 2 Goals for diabetes are BP <130/80 LDL <100
Hyperlipidemia	❑ YES	❑ NO	Check Yes if LDL >130 or on treatment regimen
Asthma			
Overweight/Obese	❑ YES	❑ NO	Check Yes if CMI is 27 or above
Current Nicotine use	❑ YES	❑ NO	Includes smoking, chewing and/or vaping

I authorize my patient to join the applicable physical activity and/or Coordinated Care Program to help maintain or improve their health status.

Provider signature: ______________________________

Please return by mail to:
Cleveland Clinic Employee Health Plan
25900 Science Park Drive, AC242
Beachwood, OH 44122

Email: ehphc@ccf.org
Fax: (216) 448-2053