We're about you

Pharmacy Health Check

1. MEMBER INFORMATION

Surname:		Name:	
Initials:		Date of birth: D D M M Y Y Y Y	Gender: Male / Female
Identity/ passport number:		Cell number:	
Work number:		Home number:	
E-mail address:		Medical aid fund:	
Medical aid fund number:		Dependant code:	
Employer:			

What is your Job level (please encircle the applicable category):

EXCO	Senior management	Junior management/Supervisor	Non managerial	Temporary Worker	Intern

2. MEDICAL HISTORY

CONDITION	DIAGNOSED	If Yes, Date Diagnosed	ON TREATMENT	
Diabetes	YES/NO		YES	NO
High Cholesterol	YES/NO		YES	NO
High Blood Pressure	YES/NO		YES	NO
Heart disease	YES/NO		YES	NO
Asthma	YES/NO		YES	NO

3. HEALTH HABITS

1. How many cups of tea/coffee do you drink per day?		2. How many servings of fruits and vegetables do you eat per day?				
3. How many times a day do you eat a meal or a snack?						
4. How many hours do you sleep per night?	7-8 hours / more	6-7 hours	5-6 hours	4-5 hours	Less than 4 hours	
5. Please mark with a **X** if you experience any of the following while sleeping?	None	Difficulty falling asleep	Interrupted sleep	Snoring	Insomnia	Obstructive sleep apnea
6. How often do you exercise?	Almost daily	3-5 times per week	1-2 times per week	A few times per month	Not at all	
7. Smoking habit	Never smoked	Ex-smoker	Vape	Less than 10 cigarettes per day	10-20 cigarettes per day	More than 20 cigarettes per day
8. Drinking habit	Never drink alcohol	Occasionally drink alcohol	1-2 drinks per day	3-4 drinks per day	More than 4 drinks per day	
9. During the past month, how often have you been so overwhelmed that you felt unable to cope with important responsibilities?	Never	Almost never	Sometimes	Fairly often	Very often	

4. GENERAL HEALTH

1. Are you currently on the Beneficiary Risk Management Programme?	YES/NO
2. Do you currently suffer from chronic back pain neck ailments?	YES/NO
3. If female, are you pregnant?	YES/NO
4. If Yes, what is your expected due date?	

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5. HEALTH RISK ASSESSMENT

TEST	RESULT	TEST	RESULT	TEST	RESULT	INTERPRETATION	
Height (No shoes)	m	Weight (No shoes)	kg	Body Mass Index (BMI)	Kg/m^2	Normal	
						Abnormal	

TEST	RESULT	TEST	RESULT	INTERPRETATION	
Hip Circumference	cm	Waist Circumference	cm	Normal	
				Abnormal	

TEST	RESULT	RESULT 2	RESULT 3	INTERPRETATION	
Blood Pressure	/ mmHg	/ mmHg	/ mmHg	Normal	
				Abnormal	
				On treatment	

TEST	RESULT	INTERPRETATION		TEST	RESULT	INTERPRETATION	
Glucose	mmol/L	Normal		Cholesterol	mmol/L	Normal	
		Abnormal				Abnormal	
		On treatment				On treatment	

Nurse Name _____ Nurse Signature _____ DATE D D M M Y Y Y Y

6. Disclaimer

My participation in the Health Risk Assessment was voluntary. By signing this form, I the undersigned, hereby voluntarily consent to the processing of my personal and health information ("confidential information") by NHP, their Managed Healthcare partner, and their affiliates, for the purpose of facilitating the HRA and rendering services associated thereto, including but not limited to screening, counselling, education and disease management.

Where necessary and only for the indicated purpose, my confidential information may be shared with NHP, their Managed Healthcare partner, and their affiliates, subject to the commitment to protect the confidential information in line with any applicable legislation. I further consent to the processing of my confidential information for historical, statistical or research purposes, provided that such information is not published in identifiable form and the processing is compatible with the original purpose of collection.

I understand that without the information, the NHP Managed Healthcare partner, and their affiliates will not be able to render the relevant services.

I understand that I have the right to access and update the information at any time, or to object to the further processing of my confidential information.

Member Name _____ Member Signature _____ DATE D D M M Y Y Y Y

PLEASE EMAIL THIS COMPLETED FORM TO PHARMACYHRA@CARE.NHP.NA.COM

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