



YOUR VISIT TODAY

THE UNIVERSITY OF ALABAMA AT BIRMINGHAM - PREVENTIVE MEDICINE

FOR OFFICE USE ONLY

APPOINTMENT TIME	AGE	HEIGHT
_____ am/pm	<input type="checkbox"/> NUTRITION	_____
_____ am/pm	<input type="checkbox"/> NURSE	_____
_____ am/pm	<input type="checkbox"/> FITNESS	_____
_____ am/pm	<input type="checkbox"/> OTHER _____	_____

Please tell us about yourself:

 Today's Date / /

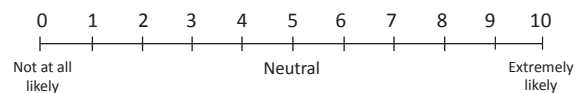
 Month Day Year

- Mr. Mrs. Ms. First _____ Middle _____ Last _____
- Address _____ City _____ State _____ Zip _____
- Phone (_____) _____ Cell (_____) _____ E-mail _____
- Occupation _____ Employer _____
- Do you live downtown? Yes No
- Do you work downtown? Yes No
- Reason for coming to UAB HealthSmart today _____

If this is your first visit to UAB HealthSmart, please continue with #8-20.

- Do you have health insurance? Yes No
- How did you hear about UAB HealthSmart? (Please choose as many as apply.)
 Passing By Direct Mail Friend E-news Office Staff Radio Television Newspaper Other _____
- What is your usual method of transportation? Walk Car Bus/Public Transportation Bike
- Date of Birth / /
 Month Day Year
- What is your gender? Male Female
- What is your race/ethnic group?
 White African American (Black) Hispanic/Latino Asian Native Hawaiian or Pacific Islander
 American Indian/Alaska Native Other
- What is the highest level of education you have completed?
 Less than High School High School Diploma/GED Some College 2-year College Degree (Associate)
 4-year College Degree (BA, BS) Master's Degree (MA, MPH, MBA) Professional Degree (MD, JD, OD) Doctoral Degree (PhD)
- What is your income? (optional) 0 - \$24,999 \$25,000 - \$49,999 \$50,000 - \$74,999 \$75,000 - \$99,999 \$100,000 or above
- May we send you announcements about our free programs and events? Yes No
- Preferred way to receive information / reminders from us: Telephone Cell E-mail Text message on your cell
- Do you have specific comments or suggestions about your visit to UAB HealthSmart today? Your participation will help us better serve you and your community.

- On a scale of 0 (not at all likely) to 10 (extremely likely), please tell us how likely you are to recommend UAB HealthSmart to others. _____



- Which of these health topics would you be interested in learning more about at UAB HealthSmart?

- | | | |
|---|--|---|
| <input type="checkbox"/> Aging | <input type="checkbox"/> Depression | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Fitness/Daily Exercise | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Healthy Eating/Nutrition | <input type="checkbox"/> Skin Health |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Heart Health | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Smoking/Tobacco |
| <input type="checkbox"/> Bone Health | <input type="checkbox"/> Hormone Therapies | <input type="checkbox"/> Stress Reduction |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Infertility | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer (Specify _____) | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Men's Health | <input type="checkbox"/> Teen Health |
| <input type="checkbox"/> Child Health | <input type="checkbox"/> Menopause | <input type="checkbox"/> Women's Health |
| <input type="checkbox"/> Dental Health | <input type="checkbox"/> Mental Health (Specify _____) | <input type="checkbox"/> Other _____ |

Services/Programs completed today:

- Health Profile
 - A1C (HEMOGLOBIN)
 - Blood Pressure
 - Body Composition
 - Glucose
 - Lipid Profile (TOTAL HDL, LDL, TG)
 - Other _____
- Health Risk Assessment (computer)
- Counseling Session
 - Nurse
 - Exercise Physiologist
 - Nutritionist
 - Other _____
- General Inquiry/Informational Visit
- Health Fair Planning
- Physical Activity Demonstration
 - WALK Feel Alive
 - Sign Up
 - Orientation
 - City WALK
 - Xbox Fitness
 - Sign Up
 - ZUMBA Fitness Class
 - Sign Up
 - Other _____
- Nutrition Demonstration
 - Sign Up
- Lunch & Learn Health Talk
 - Sign Up
- Health Education Information
- Other Services
 - Explain _____

Appointment Scheduling:

- Health Profile
 - A1C (HEMOGLOBIN)
 - Blood Pressure
 - Body Composition
 - Glucose
 - Lipid Profile (TOTAL HDL, LDL, TG)
 - Other _____
- Counseling Session
 - Nurse
 - Exercise Physiologist
 - Nutritionist
 - Other _____

Health-care Provider Recommendations (To be completed by UAB HealthSmart Health-care Provider)

Health-care provider seen today: _____

- Return in:
- 1 month
 - 3 months
 - 6 months
 - 1 year
 - Other _____

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Health Profile <ul style="list-style-type: none"> <input type="checkbox"/> A1C <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Body Composition <input type="checkbox"/> Glucose <input type="checkbox"/> Lipid Profile <input type="checkbox"/> Other _____ | <ul style="list-style-type: none"> <input type="checkbox"/> Health Risk Assessment <input type="checkbox"/> Counseling Session <ul style="list-style-type: none"> <input type="checkbox"/> Nurse <input type="checkbox"/> Exercise Physiologist <input type="checkbox"/> Nutritionist <input type="checkbox"/> Other _____ |
|---|---|

UAB HealthSmart follow-up services recommended:

Notes:



YOUR PATH TO BETTER HEALTH

UAB School of Medicine

Acknowledgement of Receipt of Notice

I understand that the UAB School of Medicine may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's Notice of Health Information Practices that describes how my health information is used and shared. I understand the organization has the right to change this notice at any time. I may obtain a current copy by contacting the School of Medicine. My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Health Information Practices.

Print (Patient's Name)

Patient Medical Record Number

Signature of Patient or Legal Representative

Date

If signed by legal representative, relationship to patient: _____

Office Use Only

Employee Name

Employee Phone Number

Consent to Photograph, Video, or Audio Record

Yes

No

By signing below, I authorize UAB HealthSmart to photograph, video record, or audio record me while participating in the UAB HealthSmart activities for the purposes of publication or marketing by UAB HealthSmart. Uses for recordings may include but are not limited to news releases, website content, printed marketing brochures, training/educational videos, or other authorized forms of organizational communication without compensation of any kind. Each communication may also reveal my name and identity in a descriptive text or commentary associated with any recordings. I relinquish all rights and privileges to any negatives, prints, audio recordings and/or video recordings created by UAB HealthSmart.

Release of Liability

I will be participating in UAB HealthSmart activities as described above for the purpose of improving my knowledge and understanding of certain wellness and chronic disease prevention activities. I hereby release UAB MHRC, UAB HealthSmart, The Board of Trustees of the University of Alabama, a body corporate which operates the University of Alabama at Birmingham, the University of Alabama School of Medicine and the University Hospital and Clinics, UAB Health System, the University of Alabama Health Services Foundation, P.C., and each of its and their divisions, departments, affiliates, related entities, and all present and former trustees, directors, officers, volunteers, employees and personnel (including all physicians and their employers, residents, fellows, interns, medical or dental students, dentists, nurses, laboratory and diagnostic personnel and other health or dental care personnel), agents, and representatives and hold them harmless for any and all liability, claims, damages, actions, and causes of action arising, directly or indirectly, from my participation in UAB HealthSmart activities, the use of any of their services, facilities, or equipment.

Signatures

By signing below, I agree to participate in the UAB HealthSmart activities described above and I release liability associated with my participation in the UAB HealthSmart activities. Unless I checked the "No" box above, I also authorize UAB HealthSmart to photograph me participating in activities.

Signature of Client

Date

Signature of UAB HealthSmart Representative

Date