



“Know Your Numbers” 2023/2024



NAME: _____

LOCATION/BUILDING: _____

NAME OF HEALTH CARE PROVIDER: _____

DATE OF VISIT: _____

WELLNESS INFORMATION RECEIVED:

!! Check those that apply — DO NOT submit numbers on this form!!

- CHOLESTEROL
- BLOOD PRESSURE
- BLOOD SUGAR
- OTHER SCREENINGS/UPDATE
- OTHER RISK RELATED INFORMATION

PHYSICIAN/HEALTH CARE PROVIDER SIGNATURE: _____

I agree that this patient has participated in a health checkup to identify their risks and make a plan.

PATIENT SIGNATURE: _____

I now have my current health information and recognize its meaning and importance.

PARTICIPANT INSTRUCTIONS

To earn 25 PATHpoints you must...

Return this form to _____ **no later than June 1, 2024.**

Your 25 PATHpoints will be awarded on or before June 15, 2024.

(only one Know Your Numbers form per points year will be accepted)