"Know Your Numbers"
2026/2027

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, 2027.

Your 25 PATHpoints will be awarded on or before June 15, 2027.

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