

INITIAL DECLIETO	EDOM DECEDDED DDOMINED
INITIAL RESULTS	FROM REFERRED PROVIDER
Date:	
Weight:	BP:
BMI:	Waist Circum:
Cholesterol:	HDL:
TC/HDL Ratio:	
Glucose (if applicable):	
(results within past 6 months	s accentable)
(Icsuits within past o months	s acceptable)

Referring Physician:		Phone:	Phone:Fax:				
Health Risk Assessment / Date Completed:							
Patient First Nar	Name: Last Name:						
Date of Birth:	Sex:						
Date of Visit	Weight	BMI	Waist Circum.	BP			
Next Appt://	Notes:						
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Patient First Name: .		Last Name:				
Data of Vigit	Waight	BMI	Waist Circum. BP			
Date of Visit	Weight	DIVII	Waist Circum.	Dr		
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Please fax to the Culinary Health Fund Wellness Department at (702) 691-5620