



**Employee Health Plan (EHP) Total Care Health Visit Report**  
Must be completed by a licensed health professional (MD, DO, NP, PA)  
*and mailed or faxed directly to the EHP Total Care*

**Date of Examination:** \_\_\_\_\_

**Provider Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Office Address: \_\_\_\_\_  
\_\_\_\_\_

Office Phone: (\_\_\_\_\_) \_\_\_\_\_

**Patient Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

EHP No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Biometric Data (required):**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_

**Lab Work (required):**

Date Drawn: \_\_\_\_\_

Cholesterol Screening Result **age 40 or older:** LDL: \_\_\_\_\_

**Chronic Disease List — Please complete all sections**

**(Check Y if patient has diagnosis, check N if screen is negative or there is no patient history):**

Hypertension: Y\_\_\_ N\_\_\_

Diabetes: Y\_\_\_ N\_\_\_ (If applicable, Type I or Type II: \_\_\_)

Hyperlipidemia: Y\_\_\_ N\_\_\_

Asthma: Y\_\_\_ N\_\_\_

Overweight/Obese: Y\_\_\_ N\_\_\_ (If BMI is above 27.0 please check yes)

Current Tobacco Use: Y\_\_\_ N\_\_\_

**Provider Signature:** \_\_\_\_\_

**Please return by mail to:**

Cleveland Clinic Employee Health Plan Total Care  
29050 Aurora Road, SCC-13  
Solon, OH 44139

**e-mail to:** [ehphc@ccf.org](mailto:ehphc@ccf.org)  
**or**  
**via fax:** 216-448-9053