Reeves County Hospital District Health Fair – Saturday, April 11, 2026

Blood Work Registration Form – Blood drawn 8:00 am to 11:00 am ONLY – *No Exceptions!*

Blood Package Cost is $40.00 PSA for men is $25.00

Do not Eat, Drink, or Take Medications at least 8 hours prior to Blood Work

Please Print Legibly!

Name _____ **Birthdate** _____ **Age:** _____ **Male** __ **Female** __

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Home/Cell Phone _____ **Email Address:** _____

Health Provider's name (Doctor): _____

If provider (doctor) is outside of Reeves County address and phone # required _____
(Health Provider's name and/or information is REQUIRED in order to draw blood)

1. ARE YOU PRESENTLY BEING TREATED FOR:

____ high blood pressure	____ lung disease	____ diabetes	____ anemia
____ high cholesterol	____ kidney disease	____ cataracts	____ gout
____ high triglycerides	____ liver disease	____ glaucoma	____ other
____ thyroid disease	____ heart disease	____ cancer	____ weight problem

2. HAVE ANY OF YOUR IMMEDIATE BLOOD RELATIVES EVER HAD:

____ high blood pressure	____ diabetes	____ cancer
____ high cholesterol	____ heart attacks	____ glaucoma

3. HAVE YOU NOTICED ANY:

____ hoarseness or cough	____ change in a mole	____ lump or thickening in breast or elsewhere
____ difficulty in swallowing	____ unusual bleeding	____ change in bowel or bladder habits

4. LIST ANY SURGERIES YOU HAVE HAD _____

_____

5. ____ No ____Yes **Do you wear a hearing aid?**
6. ____ No ____Yes **Do you wear glasses / contacts?**
7. ____ No ____Yes **Do you smoke: If yes, how many cigarettes per day?** _____
8. ____ No ____Yes **Do you have a chronic morning cough?**
9. ____ No ____Yes **Do you have shortness of breath or pain in the chest after exercise?**
10. ____ No ____Yes **Are you currently being treated for an illness? What?** _____
11. ____ No ____Yes **Do you diet regularly or frequently?**
12. ____ No ____Yes **Do you exercise regularly?**
13. ____ No ____Yes **Do you drink more than 2 alcoholic beverages per day?**
14. ____ No ____Yes **Are you constantly under stress at work or at home?**
15. ____ No ____Yes **Are you taking any medications? List:** _____
_____
16. ____ No ____Yes **In the last year, have you made a change in your lifestyle to improve your health?**
17. When was the last time you had a complete check up WHEN YOU WERE NOT SICK?
____ 1 -5 months ____ 6 -11 months ____ 1 -2 years ___ More than 2 years ____ Never

18. Number of hours since you had anything to eat or drink? _____ ****For accurate results patients should be fasting for at least 8 hours – preferably 12 hours. This includes no water and no medication.**

19. Consent form signed? ____ No ____Yes **Receipt #** _____
20. Health Fair results will be mailed out 2 weeks after the Health Fair.

REEVES COUNTY HOSPITAL DISTRICT ANNUAL HEALTH FAIR
Patient Consent and Release and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services that Reeves County Hospital District creates and maintains health records and other information describing among other things my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for my future care or treatment.

I understand, upon my request, I may be provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and Practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health operations (quality assessment and improvement activities, underwriting premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization 8s not required to agree to the restriction requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all health records, whether written or oral or in electronic format, are confidential and can not be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use of my Protected Health Information and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have previously been agreed upon.

I hereby request that health procedures / blood tests be performed for me by the organizations participating in the Reeves County Hospital District Annual Health Fair under the sponsorship of the Reeves County Hospital District. I understand that all procedures / blood tests will be performed without any charge to me whatsoever except for the optional blood tests, PSA, and EKG's for which a nominal fee to cover expenses will be charged.

I hereby release all participating organizations, from any and all liability, which may arise from such procedures and/or blood tests, or from the data derived there from.

It is understood that:

1. The data derived from such procedures / blood tests is to be considered preliminary and in no way conclusive;

2. The responsibility of initiating any follow up examinations for abnormalities at the Health Fair lies with me as the person responsible for my own health and not with any participating organization.

_____ April 11, 2026_____

Signature Date