

Health Screening Form

Patient to Complete				
First Name	Last Name	Date of Birth	Gender	
Address		City	State	Zip Code
Email		Preferred Phone Number		
Office Use Section 1: General Health <input type="checkbox"/> Required	In the last 7 days, have you had any of the following symptoms			
	<input type="checkbox"/> Fever (37.5°C or above)	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Congestion or Runny Nose	
	<input type="checkbox"/> Cough	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Nausea or Vomiting	
	<input type="checkbox"/> Chills	<input type="checkbox"/> Headache	<input type="checkbox"/> Diarrhea	
Office Use Section 2: Chronic Condition <input type="checkbox"/> Required	Please check those conditions that you have now, or have had in the past			
	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Asthma/Bronchitis	<input type="checkbox"/> High Cholesterol	
	<input type="checkbox"/> Angina	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Diabetes	
	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Chronic Kidney Disease	
Office Use Section 3: Infectious Diseases <input type="checkbox"/> Required	Please check those conditions that you have now, or have had in the past			
	<input type="checkbox"/> Hepatitis A (HAV)	<input type="checkbox"/> HIV	<input type="checkbox"/> Gonorrhea	
	<input type="checkbox"/> Hepatitis B (HBV)	<input type="checkbox"/> Herpes	<input type="checkbox"/> Chlamydia	
	<input type="checkbox"/> Hepatitis C (HCV)	<input type="checkbox"/> HPV or Anal/Genital Warts	<input type="checkbox"/> Syphilis	
	<input type="checkbox"/> Viral Hepatitis	<input type="checkbox"/> Tuberculosis		
Other Conditions/Additional Comments:				
I authorize my healthcare provider to release the requested information to third party of interest. I confirm that the information above is true to the best of my knowledge.				
				_____ Patient Signature
Physician Office to Complete				
Height	Weight	Waist	Heart Rate	
Blood Pressure	Blood Glucose (Fasting)	Blood Glucose (Non-fasting)		HbA1c
Total Cholesterol	TAG/Triacylglycerol	LDL	HDL	Ratio (TAG to HDL)
Additional Comments:				
				<input type="checkbox"/> Patient Pregnant
Date of Examination	Clinician Name		Clinician Signature	