# Health Screening Form

| | | |
|---|---|---|
| **Patient section** | | |
| **Patient details** | | |
| First name: | Last name: | |
| Date of birth: | Sex: | |
| Address: | | |
| City: | State: | Zip code: |
| Email address: | Phone number: | |
| Emergency contact name: | | |
| Relationship with patient: | | |
| Emergency contact information: | | |
| **Office section** | | |
| **General health** | | |
| ☐ Required | | |
| Instructions: Check the symptoms you recently had or currently have. | | |
| ☐ Fever (37.5°C or above)<br>☐ Cough<br>☐ Chills | ☐ Shortness of breath<br>☐ Sore throat<br>☐ Headache | ☐ Congestion or runny nose<br>☐ Nausea or vomiting<br>☐ Diarrhea<br>☐ Other: |
| **Chronic conditions/illnesses** | | |
| ☐ Required | | |
| Instructions: Check the conditions that you have now or have had in the past. | | |
| ☐ Heart problems<br>☐ Angina<br>☐ High blood pressure | ☐ Asthma/bronchitis<br>☐ Epilepsy<br>☐ Arthritis | ☐ High cholesterol<br>☐ Diabetes<br>☐ Chronic kidney disease<br>☐ Other: |

**Infectious diseases**

☐ Required

Instructions: Check the conditions that you have now or have had in the past.

| | | |
|---|---|---|
| ☐ Hepatitis A (HAV) | ☐ HIV | ☐ Gonorrhea |
| ☐ Hepatitis B (HBV) | ☐ Herpes | ☐ Chlamydia |
| ☐ Hepatitis C (HCV) | ☐ HPV or anal/genital warts | ☐ Syphilis |
| ☐ Viral hepatitis | ☐ Tuberculosis | ☐ Other: |

**Other information**

☐ Required

Please list down any other relevant information you have regarding your family or medical history including allergies, past injuries, past surgeries, and chronic illnesses.

Please list down any medications and/or supplements you've taken or are currently taking. Include the dosage, frequency, and reactions/side effects, if any.

Please describe your lifestyle (e.g. smoking habits, alcohol consumption, physical fitness, nutrition, etc.).

I authorize my healthcare provider to release the requested information to a third party of interest. I confirm that the information above is true to the best of my knowledge.

Patient's signature:

Date:

| **Healthcare provider section** | | |
|---|---|---|
| Screening date: | | |
| Clinician name: | | |
| Contact information: | | |
| **Patient information** | | |
| Height: | Weight: | Waist: |
| Heart rate: | Blood pressure: | HbA1c: |
| HDL: | LDL: | Non-HDL: |
| Blood glucose (fasting): | Blood glucose (non-fasting): | |
| Total cholesterol: | TAG/Triacylglycerol/Triglycerides: | |
| TG or TAG/HDL ratio: | Pregnant: ☐ Yes ☐ No | |
| Notes or additional comments: | | |
| | | |
| Clinician signature: | | |