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
☐ Required

In the last 7 days, have you had any of the following symptoms

- ☐ Fever (37.5°C or above)
- ☐ Shortness of Breath
- ☐ Congestion or Runny Nose
- ☐ Cough
- ☐ Sore Throat
- ☐ Nausea or Vomitting
- ☐ Chills
- ☐ Headache
- ☐ Diarrhea

Office Use
Section 2: Chronic Condition
☐ Required

Please check those conditions that you have now, or have had in the past

- ☐ Heart Problems
- ☐ Asthma/Bronchitis
- ☐ High Cholesteral
- ☐ Angina
- ☐ Epilepsy
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Chronic Kidney Disease

Office Use
Section 3: Infectious Diseases
☐ Required

Please check those 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 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:

☐ Patient Pregnant

Date of Examination	Clinician Name	Clinician Signature