

Health Screening Form

PATIENT DETAILS

Name and date of birth: _____

Sex: _____

☐ Male ☐ Female

Address: _____

City: _____

State: _____

Zip code: _____

Email address: _____

Relationship with patient: _____

Emergency contact information: _____

GENERAL HEALTH

Instructions: Check the symptoms you recently had or currently have.

Symptoms

- ☐ Fever (37.5°C or above)
- ☐ Chills
- ☐ Sore throat
- ☐ Congestion or runny nose
- ☐ Diarrhea

- ☐ Cough
- ☐ Shortness of breath
- ☐ Headache
- ☐ Nausea or vomiting

CHRONIC CONDITIONS/ILLNESSES

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

Chronic conditions/illnesses

- ☐ Heart problems
- ☐ High blood pressure
- ☐ Epilepsy
- ☐ High cholesterol
- ☐ Chronic kidney disease

- ☐ Angina
- ☐ Asthma/bronchitis
- ☐ Arthritis
- ☐ Diabetes

INFECTIOUS DISEASES

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

Infectious diseases

- ☐ Hepatitis A (HAV)
- ☐ Hepatitis C (HCV)
- ☐ HIV
- ☐ HPV or anal/genital warts
- ☐ Gonorrhea
- ☐ Syphilis

- ☐ Hepatitis B (HBV)
- ☐ Viral hepatitis
- ☐ Herpes
- ☐ Tuberculosis
- ☐ Chlamydia
- ☐ Other

OTHER INFORMATION

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: _____ dd / mm / yyyy

HEALTHCARE PROVIDER SECTION

Screening date: _____ dd / mm / yyyy Clinician name: _____

Contact information: _____

PATIENT INFORMATION

Height: _____ Weight: _____

Waist: _____ Heart rate: _____

Blood pressure: _____ Blood glucose (fasting): _____

Blood glucose (non-fasting): _____ HbA1c: _____

Total cholesterol: _____ TAG/Triacylglycerol/Triglycerides: _____

HDL: _____ LDL: _____

Non-HDL: _____ TG or TAG/HDL ratio: _____

Pregnant: _____

☐ Yes ☐ No

Notes or additional comments:

Clinician signature: