

Health Screening Form

Patient to Complete					
First Name		Last Name		Date of Birth	
Address		City		State	
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 Cholesterol ☐ 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	
Blood Pressure		Blood Glucose (Fasting)		Blood Glucose (Non-fasting)	
Total Cholesterol		TAG/Triacylglycerol		HDL	
				Ratio (TAG to HDL)	
Additional Comments:					
☐ Patient Pregnant					
Date of Examination		Clinician Name		Clinician Signature	