Health Record Form Online

Patient Information

- **Full Name: ____**
- **Health ID Number: ___________________________________**
- **Email: ____**
- **Phone Number: ______________________________________**
- **Address: ____**

Online Health Assessment

Question	Yes ☐	No ☐	Additional Notes
Have you experienced a recent fever?			
Any history of COVID-19 infection?			
Do you have chronic respiratory issues?			
Are you currently taking medication?			
Have you undergone surgery recently?			

Digital Signature

- ☐ **I acknowledge that the information provided is accurate and up-to-date.**
- ☐ **I agree to the online privacy policy.**

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Signature: ____

Date: ____

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