**Health Screening Questionnaire Word**

#### **Medical Health Screening Form**

**Patient Information
Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_
Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**General Health Status
Do you currently feel unwell? [ ] Yes [ ] No
Do you have any existing medical conditions? [ ] Yes [ ] No
If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Recent Symptoms
Have you experienced any of the following in the last 14 days?**

* **Fever or chills [ ] Yes [ ] No**
* **Cough or sore throat [ ] Yes [ ] No**
* **Shortness of breath [ ] Yes [ ] No**
* **Loss of taste or smell [ ] Yes [ ] No**

**Vaccination & Immunization
Have you received the required vaccinations? [ ] Yes [ ] No
Date of last flu shot: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mental Health & Stress Management
Do you feel stressed frequently? [ ] Yes [ ] No
Would you like to receive mental health support? [ ] Yes [ ] No**

**Acknowledgment & Consent
I confirm that the provided details are accurate.
Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**