**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**