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: _____