# Health Screening Questionnaire

**Purpose:** This questionnaire is designed to identify potential health risks, symptoms, or conditions that may need to be addressed before medical procedures or appointments. The information provided will be used to ensure the safety and effectiveness of your care.

## Patient Information

* **Full Name:** {fullName}
* **Date of Birth:** {dateOfBirth}
* **Gender:** {gender}
* **Phone Number:** {phoneNumber}
* **Email Address:** {email}

## Emergency Contact

* **Name:** {emergencyContactName}
* **Phone Number:** {emergencyContactPhone}
* **Relationship:** {emergencyContactRelation}

## Current Symptoms & Health Conditions

{#symptoms}

* {description}

{/symptoms}

## Pre-existing Conditions

{#conditions}

* {conditionName}

{/conditions}

## Medications

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** |
| {#medications}{medicationName} | {dosage} | {frequency}{/medications} |

## Allergies

{#allergies}

* {allergen} – *{reaction}*

{/allergies}

## Travel History (Last 30 Days)

{#travelHistory}

* {location} on {travelDate}

{/travelHistory}

## Contact History

{#contactHistory}

* Contact with **{contactPerson}** on {contactDate}

{/contactHistory}

## Lifestyle Information

* **Do you smoke?:** {smokes}
* **Do you consume alcohol?:** {drinksAlcohol}
* **How often do you exercise?:** {exerciseFrequency}

## Insurance Information

{#hasInsurance}

* **Insurance Provider:** {insuranceProvider}
* **Policy Number:** {insurancePolicyNumber}

{/hasInsurance}

{^hasInsurance}

*This patient does not have health insurance.*

{/hasInsurance}

## Consent

I, **{fullName}**, confirm that the information provided in this form is accurate to the best of my knowledge. I understand this information is used to assess my current health status before undergoing any procedure or consultation.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: {formDate}