

Health Screening Questionnaire

NAME _____ DATE _____

Directions: Please answer the following questions by circling yes or no based on the last 12-month. Please explain any yes answers at the bottom of the page. Have you had, or have you experienced:

- 1 Yes No A cough lasting more than three months.
- 2 Yes No Coughing up blood.
- 3 Yes No An unexpected low-grade fever (99-100 degrees F) lasting more than a week.
- 4 Yes No Loss of appetite/unexplained nausea.
- 5 Yes No Weight loss not due to dieting.
- 6 Yes No Unexplained weakness.
- 7 Yes No Unexplained joint pain.
- 8 Yes No Swollen glands.
- 9 Yes No Changes in stool color/consistency.
- 10 Yes No Yellowing of skin/sclera.
- 11 Yes No Dark urine coloration
- 12 Yes No Unexplained itchy/irritated skin.
- 13 Yes No Waking up at night sweating.
- 14 Yes No Unexplained irregular menstrual cycle.
- 15 Yes No Easily fatigued.
- 16 Yes No Pain when you breath.

Have you had a chest x-ray within the past 12 months.
(If Yes),Date _____ Physician's Name _____
Location _____

(Yes answers-please explain)

Nurse Signature _____ Date _____