



# GONZABA

## MEDICAL GROUP

### Health Screening Consent Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Sex: Female Male (circle one)

Address: \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**I am requesting this test for screening purposes only and understand that only my doctor may diagnose my condition. Individuals who are symptomatic or otherwise at high risk should be seen for specific testing in addition to this screening. As a participant in this screening, I hereby waive any and all claims against the sponsors of this screening, its employees, agents, and medical staff connected with or arising out of services rendered in connection with this screening.**

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

*(Must be 17 years of age or older or legal guardian must be present to sign.)*

#### Screening Results

Blood Pressure: \_\_\_\_\_ Normal Range: 120/80 to 140/90  Please see physician

Cholesterol: \_\_\_\_\_ Normal Range: Less than 200  Please see physician

Glucose: \_\_\_\_\_ Normal Range: Less than 125  Please see physician

#### **MAIN CLINIC:**

720 PLEASANTON ROAD  
(210) 921-3800

#### **WOODLAWN CLINIC:**

902 BANDERA ROAD  
(210) 431-4503

#### **NORTHWEST CLINIC:**

7616 CULEBRA, STE. 130  
(210) 509-2603

#### **SOUTHEAST CLINIC:**

4212 E. SOUTHCROSS ST.  
(210) 333-3066