**Health Questionnaire For Employees**

**Employee Information
Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_
Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Emergency Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**General Health Information
Do you have any chronic medical conditions? [ ] Yes [ ] No
If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently taking any medications? [ ] Yes [ ] No
If yes, list medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had any major surgeries in the past 5 years? [ ] Yes [ ] No
If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Workplace Health Risks
Do you experience stress-related issues at work? [ ] Yes [ ] No
Have you had any workplace injuries? [ ] Yes [ ] No
Do you require any workplace accommodations? [ ] Yes [ ] No**

**Lifestyle & Wellness
Do you smoke or use tobacco products? [ ] Yes [ ] No
How often do you exercise per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do you follow a balanced diet? [ ] Yes [ ] No**

**Mental Health Assessment
Have you experienced anxiety or depression in the last year? [ ] Yes [ ] No
Would you like mental health support at work? [ ] Yes [ ] No**

**Certification
I certify that the information provided is accurate to the best of my knowledge.
Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**