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: _____