**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**