**Health Risk Assessment Questionnaire PDF**

**Personal Information
Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_
Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History
Do you have a family history of chronic illnesses? [ ] Yes [ ] No
If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you been diagnosed with high blood pressure? [ ] Yes [ ] No
Do you have diabetes or prediabetes? [ ] Yes [ ] No**

**Cardiovascular Health
Have you ever experienced chest pain or shortness of breath? [ ] Yes [ ] No
Have you been diagnosed with high cholesterol? [ ] Yes [ ] No**

**Physical Activity & Nutrition
Do you engage in regular physical activity? [ ] Yes [ ] No
How many servings of fruits and vegetables do you eat daily? \_\_\_\_\_\_\_\_\_\_**

**Smoking & Alcohol Consumption
Do you smoke? [ ] Yes [ ] No
Do you consume alcohol? [ ] Yes [ ] No**

**Mental & Emotional Well-being
Do you experience frequent stress or anxiety? [ ] Yes [ ] No
Do you have difficulty sleeping? [ ] Yes [ ] No**

**Consent & Acknowledgment
I acknowledge that the provided information is accurate.
Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**