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: _____