Employee Health Risk Assessment Questionnaire

Personal Information

Full Name

Email

Age

Gender

Lifestyle

Do you smoke?

Yes

No

Do you consume alcohol?

Yes

No

How many days per week do you exercise?

Medical History

Do you have any chronic diseases?

Yes

No

If yes, please specify

Do you take any regular medication?

Yes

No

If yes, please specify

Family History

Please list any significant family medical history

Additional Comments