Telehealth Initial Health Risk Survey

Personal Information

Full Name

Date of Birth

Gender

Phone Number

Email

Medical History

Do you have any chronic conditions? If yes, please list.

Current medications (if any)

Lifestyle & Habits

Do you smoke?

Do you consume alcohol?

Physical activity level (e.g., sedentary, moderate, active)

Current Symptoms

Are you currently experiencing any symptoms?

Other health concerns