Chronic Disease Self-Check Form

Full Name

Age

Gender

Chronic Disease History

Have you been diagnosed with any of the following chronic diseases?

- [ ] Diabetes
- [ ] Hypertension
- [ ] Asthma
- [ ] Heart Disease
- [ ] Kidney Disease
- [ ] Other
- [ ] None

If diagnosed, for how many years have you had the disease(s)?

List your current medications

Recent Symptoms

Are you currently experiencing any of these symptoms? (Check all that apply)

- [ ] Shortness of breath
- [ ] Chest pain
- [ ] Fatigue
- [ ] Swelling (ankles, feet, hands)
- [ ] Frequent urination

- [ ] Unexplained weight change
- [ ] None

Other symptoms (please specify)

Lifestyle & Monitoring

How often do you monitor your condition?

- ( ) Daily
- ( ) Weekly
- ( ) Monthly
- ( ) Rarely

Additional remarks