Senior Citizen Health Risk Questionnaire

Personal Information

Full Name

Date of Birth

Gender

Medical History

Do you currently have or have you ever been diagnosed with any of the following?

- [ ] Diabetes
- [ ] Hypertension
- [ ] Heart Disease
- [ ] Stroke
- [ ] Cancer
- [ ] Asthma
- [ ] Arthritis
- [ ] None

Other medical conditions (please specify)

Lifestyle

Do you smoke?

- ○ Yes
- ○ No
- ○ Former Smoker

Do you consume alcohol?

- ○ Yes
- ○ No
- ○ Occasionally

How many days per week do you exercise?

Functional Assessment

Do you require assistance with any of the following activities?

- [ ] Bathing

- [ ] Dressing
- [ ] Eating
- [ ] Toileting
- [ ] Mobility
- [ ] None

Additional Comments

Please provide any other relevant information