

General Survey Nursing

Thank you for taking the time to complete this health survey. Your responses will help us better understand your health status and provide you with the best care possible.

Personal Information

Name:

Date of Birth:

Gender: Male Female Other:

Contact Number:

Email:

General Health

a. How would you rate your overall health?

Poor Fair Good Excellent

b. Do you have any chronic medical conditions?

Yes No

If yes, please list them.

c. Are you currently taking any medications?

Yes No

If yes, please provide details.

Lifestyle

a. Do you smoke?

Yes No

If yes, how many cigarettes per day?

b. Do you consume alcohol?

Yes No

If yes, how many drinks per week?

c. How would you describe your diet?

Unhealthy Moderately Healthy Healthy

d. How often do you engage in physical activity?

Never Rarely Occasionally Regularly

Family Medical History

Are there any significant medical conditions or diseases that run in you family? Please specify.

Mental Health

a. Have you ever been diagnosed with a mental health condition?

Yes No

If yes, please provide details.

b. How would you rate your stress level on a scale of 1 to 10?

Allergies

Do you have any known allergies?

Yes No

If yes, please specify the allergies.

Immunizations

Are your vaccinations up to date?

Yes No

If not, please specify which ones are overdue.

Women's Health (if applicable)

a. Are you pregnant or trying to conceive?

Yes No

b. Last menstrual period (if applicable):

Recent Health Events

Have you have any surgeries, hospitalizations, or significant health events in the past year?

Yes No

Please provide details.

Additional Comments

Is there anything else you would like to share about your health that has not been covered in the survey?

Thank you for completing the survey! Your health information is confidential and will be used for healthcare purposes only. Please contact us if you have any concerns or questions.