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Health and Lifestyle Assessment Questionnaire (KYN & Occupational Health)

Your Wellness International Ltd Health Assessment has been designed to help you look after your personal wellbeing by providing a detailed picture of how healthy you are now, together with guidance on how to protect your health for the future. To do this we need to know a little more about you. This questionnaire gives us information about your health and health concerns.

You should complete all the sections of this confidential questionnaire as fully as possible.
Don't worry if there are any questions you can't answer- these can be discussed during your assessment.

Your Details

Title	☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mx	Other	
First Name		Surname	
Previous Name (If applicable)			
Date of Birth		Age	
Home Address		Postcode	
Home Tel Number		Work Tel Number	
Mobile Tel Number			
Email Address			

Keeping Your GP Informed

A referral form may be given to you today to take to your GP to advise of any abnormalities or significant results that may require follow-up or further investigation. However there may be instances where we will need to contact your GP directly. Please indicate whether or not you are happy for us to do so where applicable.

Your GP

Yes ☐ No ☐

GP Name	
GP Address	
Postcode	
GP Tel Number	

Your Medical History
Please indicate if you have suffered from any of the following conditions:

Details
(Age at diagnosis and any other details)

1. Coronary Heart Disease (e.g. angina, heart attack, etc.)	Yes ☐	No ☐	
2. Cerebrovascular Disease (e.g. stroke)	Yes ☐	No ☐	
3. Cancer (please identify type)	Yes ☐	No ☐	
4. Diabetes (insulin dependent diabetes mellitus)	Yes ☐	No ☐	
5. Diabetes (non-insulin dependent diabetes mellitus)	Yes ☐	No ☐	
6. High blood pressure	Yes ☐	No ☐	
7. High cholesterol	Yes ☐	No ☐	
8. Asthma	Yes ☐	No ☐	
9. Allergies	Yes ☐	No ☐	

Previous Surgery

1. Have you ever had surgery?	Yes ☐	No ☐	

Medication
Please detail any medications and supplements including name, dose and frequency?

Smoking History and Alcohol Consumption

Please answer the questions below as honestly as possible.

Tick one answer only.

1. Please indicate your smoking history (this includes social smoking)

- ☐ Never
- ☐ Quit more than 5 years ago
- ☐ Quit less than 5 years ago
- ☐ Current smoker

2. Alcohol (units consumed per week)
(1 unit = 1 small glass of wine [125ml], 1 measure of spirit, ½ pint of beer or lager)

- ☐ None
- ☐ Less than 14 units
- ☐ More than 14 units

Your Family Medical History
Please indicate if any of your family have suffered from any of the following conditions:

Relationship
(GM=Grandmother, GF=Grandfather, M=Mother, F=Father, S=Sister, B=Brother)

	GM	GF	M	F	S	B	Details **(age at diagnosis, any other details).**
Coronary Heart Disease (e.g. angina, heart attack, etc.)	☐	☐	☐	☐	☐	☐	
Cerebrovascular accident (e.g. stroke, TIA)	☐	☐	☐	☐	☐	☐	
Cancer (please identify type)	☐	☐	☐	☐	☐	☐	
Diabetes (insulin dependent diabetes mellitus)	☐	☐	☐	☐	☐	☐	
Diabetes (non-insulin dependent diabetes mellitus)	☐	☐	☐	☐	☐	☐	
High blood pressure	☐	☐	☐	☐	☐	☐	
High cholesterol	☐	☐	☐	☐	☐	☐	
Other:							

Physical Activity

Please tell us the type and amount of physical activity involved in your work.
Please mark one box only.

- ☐ I am not in employment (e.g. retired, retired for health reasons, unemployed, full time carer or similar).
- ☐ I spend most of my time at work sitting (such as in an office).
- ☐ I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hair dresser, security guard, child minder or similar).
- ☐ My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, hospital nurse, gardener, postal delivery worker or similar).
- ☐ My work involves vigorous physical activity including handling of heavy objects (e.g. scaffolder, construction worker, refuse collector or similar).

During the last week, how many hours did you spend on each of the following activities?

	None	Some but less than 1 hour	1 hour or more but less than 3 hours	3 hours or more
Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout or similar	☐	☐	☐	☐
Cycling, including cycling to work and during leisure time.	☐	☐	☐	☐
Walking, including walking to work, shopping for pleasure or similar	☐	☐	☐	☐
Housework, childcare or similar	☐	☐	☐	☐
Gardening, DIY or similar	☐	☐	☐	☐

How would you describe your usual walking pace?
Please mark one box only.

☐ Slow pace ☐ Brisk pace

☐ Steady average pace ☐ Fast pace (for example over 4mph)

Monitoring Further Action

Please indicate whether you consent for a Wellness International Clinician to contact you regarding your results where applicable, and please state which method of contact you prefer to receive correspondence via:

☐ Yes ☐ No

Telephone:

Email address:

Or postal address:

Disclaimer & Consent

The information I have provided in this questionnaire is a true and accurate record:

I understand that it is my responsibility to act on the advice given and to contact my GP should referral be recommended:

The testing procedure has been explained to me (including finger prick, venepuncture and urinalysis test where applicable). I understand the procedure and I am happy to proceed:

Please Sign Date

Please tell us your main reasons for attending

☐ Review of health ☐ Company requirement ☐ Medical problem ☐ Other reason

Do you have any specific areas of health interest or concern? Please give details:

OFFICE USE ONLY:
I declare that I have read and verified the provided information with the patient

Signature Print Name

Position Date