QUESTIONNAIRE FORM

Participant Information:

Full Name: _____

Date of Birth: _____

Gender: _____

Address: _____

Phone Number: _____

Email Address: _____

Section 1: Medical History

1. Do you have any allergies? (If yes, please specify)

_____

2. Are you currently taking any medications? (If yes, please list)

_____

3. Do you have any chronic illnesses or conditions? (If yes, please describe)

_____

4. Have you had any surgeries in the past 5 years? (If yes, please provide details)

_____

5. Do you have any history of heart disease, diabetes, or respiratory problems?

_____

6. Are you pregnant or breastfeeding?

_____

7. Do you suffer from epilepsy, seizures, or fainting spells?

_____

8. Do you have any physical disabilities or limitations?

_____

9. Have you had any recent hospitalizations?

_____

10. Do you smoke or use tobacco products?

_____

Section 2: Lifestyle and Habits

11. How often do you exercise per week? (Frequency and type)

_____

12. Do you consume alcohol? (If yes, how often?)

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13. Do you follow any specific diet or nutrition plan?

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14. Do you use recreational drugs? (If yes, please specify)

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15. How many hours of sleep do you get on average per night?

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16. Do you have any stress management techniques you use regularly?

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17. Have you experienced any significant life changes recently?

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18. Do you have any concerns about your mental health?

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19. Do you have a regular healthcare provider?

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20. Are you up to date with your vaccinations?

Section 3: Consent and Acknowledgment

I hereby certify that the information provided above is true and correct to the best of my knowledge. I understand that providing false information may result in disqualification from participation. I consent to the use of this information for the purposes of evaluation and record keeping in accordance with applicable United States laws regarding privacy and data protection.

Participant's Signature: _____

Date: _____