# Heart Health Questionnaire

Thank you for taking the time to complete this questionnaire. Your responses will help us better understand your heart health and provide tailored advice or resources. Please answer the following questions as accurately as possible.

## Personal Information

1. Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Date of Birth (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Gender (Male/Female/Other): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Medical History

7. Do you have a history of heart disease? (Yes/No): \_\_\_\_\_\_\_

8. Have you ever been diagnosed with high blood pressure? (Yes/No): \_\_\_\_\_\_\_

9. Have you ever been diagnosed with high cholesterol? (Yes/No): \_\_\_\_\_\_\_

10. Do you have a family history of heart disease? (Yes/No): \_\_\_\_\_\_\_

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Lifestyle

11. How often do you exercise? (Daily/Weekly/Occasionally/Never): \_\_\_\_\_\_\_

12. Do you smoke? (Yes/No): \_\_\_\_\_\_\_

13. Do you consume alcohol? (Yes/No): \_\_\_\_\_\_\_

If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. How would you rate your diet? (Healthy/Moderate/Poor): \_\_\_\_\_\_\_

## Stress and Mental Health

15. How often do you feel stressed? (Always/Sometimes/Rarely/Never): \_\_\_\_\_\_\_

16. Do you practice stress management techniques (e.g., meditation, yoga)? (Yes/No): \_\_\_\_\_\_\_

## Current Symptoms

17. Have you experienced any of the following symptoms recently?

- Chest pain or discomfort (Yes/No): \_\_\_\_\_\_\_

- Shortness of breath (Yes/No): \_\_\_\_\_\_\_

- Irregular heartbeat (Yes/No): \_\_\_\_\_\_\_

- Swelling in legs or feet (Yes/No): \_\_\_\_\_\_\_

- Dizziness or light-headedness (Yes/No): \_\_\_\_\_\_\_

## Consent

By completing this questionnaire, I consent to the use of my information for the purpose of assessing my heart health and providing recommendations. I understand that my information will be kept confidential.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_