

Customize your Resume

Employee Wellness Survey

Date: _____ Age: _____

Race: _____ Gender: _____

Do you now, or have you in the past, suffered from any of the following conditions?

Allergies	Yes	No	Anemia	Yes	No	Asthma	Yes	No
Diabetes	Yes	No	Hearing loss	Yes	No	Heart disease	Yes	No
High blood pressure	Yes	No	Joint disorders	Yes	No	Sinus infections	Yes	No
Stomach disorders	Yes	No	Vision problems	Yes	No			

Are you currently under a physician's care for any chronic condition or illness?	Yes	No
Are you currently taking any prescription medications?	Yes	No
If taking medication, do you expect to be doing so long term?	Yes	No

Do you currently use tobacco products? If so, how often?

Daily	Weekly	Monthly	Occasionally
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Approximately how many cigarettes (or equivalent) do you smoke per day? _____

- How often do you perform aerobic exercise?
- a) Daily
 - b) Two or more times per week
 - c) Two or more times per month
 - d) Monthly
 - e) Less than once per month

- Are you at or near the ideal weight for your age, gender and height?
- a) Yes
 - b) No
 - c) Uncertain
 - d) Prefer not to answer

- How often do you consume soda?
- a) Several times a day
 - b) Once daily
 - c) Several times a week
 - d) Rarely
 - e) Never

- How often do you consume fast food meals?
- a) Daily
 - b) A few times each week
 - c) Weekly
 - d) Rarely