# 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.

| **Patient information** | |
|---|---|
| Full name: | |
| Date of birth: | Gender: |
| Contact number: | Email address: |
| **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 below: | |
| | |
| **C. Are you currently taking medications?** | |
| ◯ Yes ◯ No | |
| If yes, please list them below: | |
| | |
| **Lifestyle** | |
| **A. Do you smoke?** | |
| ◯ Yes ◯ No | |
| If yes, please indicate how many cigarettes per day: | |
| **B. Do you consume alcohol?** | |
| ◯ Yes ◯ No | |
| If yes, please indicate how many glasses or bottles you drink per week: | |

**C. How would you describe your current diet?**

◯ Unhealthy ◯ Moderately healthy ◯ Completely 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, what were you diagnosed with? Please elaborate.

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

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Please explain why you rated yourself that way:

## Pain

**A. Are you currently feeling any pain?**

◯ Yes ◯ No

If yes, where is the pain located? Can you describe the pain? Please elaborate.

**B. How would you rate the pain intensity from 1 to 10?**

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Please explain why you rated yourself that way:

**Allergies and immunizations**

**A. Do you have any known allergies?**

○ Yes ○ No

If yes, what are your allergies? Please list them below.

**B. Are your immunizations up to date?**

○ Yes ○ No

If yes, what vaccinations are still pending? Please list them below.

**Women's health (if applicable)**

**A. Are you pregnant or trying to conceive?**

○ Pregnant ○ Trying to conceive ○ Neither

**B. When was your last menstrual period (if applicable):**

**Recent health events**

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

○ Yes ○ No

If yes, please provide all possible details below:

| Additional comments |
| --- |
| Is there anything else you want to share about your health that has not been covered in the survey? If so, please detail them below. |
| |
| 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. |
| Signature: |
| Date signed and submitted: |