**Preliminary health status assessment form**

**Date:**

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| **Completion guidelines** | In order to have your health status assessed as accurately as possible, please fill in the below form on your device and, following the instructions on the website, send it via e-mail one day before the counselling at the latest. Filling in the form does not require any clinical findings or other documents; it serves the purpose of preparing a customized health plan that suits your health status and lifestyle. Please fill in the form as accurately as possible, as it is the prerequisite of the personal counselling. |
| **1. Patient data** |
| **Name:** |  | **Date of Birth:** |  |
| **Height:** |  **cm** | **Sex:** | MALE | FEMALE |
| **Weight:** |  **kg** | **Status:** | STUDENT | EMPLOYEE | RELATIVE |

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| **2. Data pertaining to diagnosed, current diseases** |
| 2.1 Have you been diagnosed with a chronic disease or any condition that requires treatment? | YES | NO |
| 2.2 If you answered ’YES’ to the question above, please indicate below if you have been diagnosed with any of the following diseases or conditions. If you answered ’NO’, please move on to the next point. |
| Hypertension | [ ]  | Cerebrovascular disease requiring treatment (TIA, stroke, etc.) | [ ]  |
| Ischaemic heart disease, prior infarction | [ ]  | Other neurological disorder requiring care (epilepsy, multiple sclerosis, etc.) | [ ]  |
| Diabetes[ ]  type 1[ ]  type 2 | [ ]  | Chronic kidney disease | [ ]  |
| Lipid metabolism disorder | [ ]  | Psychiatric disorder requiring care | [ ]  |
| Chronic respiratory disease (COPD, asthma, etc.) | [ ]  | Gastrointestinal disease requiring treatment (Crohn’s disease, ulcerative colitis, liver diseases, etc.)NAMELY: | [ ]  |
| Endocrine disease requiring treatment, **NAMELY:** | [ ]  | Communicable disease requiring treatment (TB, HIV, HBV, HCV, etc.) | [ ]  |
| Hematologic disease requiring treatment | [ ]  | Tumour | [ ]  |
| Diseases of the senses (vision, hearing) | [ ]  | Chronic locomotive organ disease | [ ]  |
| Injury requiring aftercare | [ ]  | Other disease or condition not listed above NAMELY: | [ ]  |

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| **3. Significant chronic diseases occurring in the family** | YES | NO |
| 3.1 If you answered ’YES’ above, please also provide your answers below. If you answered ’NO’, please move on to the next point. |
| Mother’s diseases | [ ]  | What are they? |
| Father’s diseases | [ ]  | What are they?  |
| Siblings’ diseases | [ ]  | What are they?  |

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| **4. Further medical history**Please indicate the relevance of the points below by placing an ’X’ in the appropriate boxes. |
| Regular medication | [ ]  | Please, provide a list of your medications and their frequency: |
| Drug allergy | [ ]  | Please, provide a list of drugs and active ingredients: |
| Other allergies (including food allergy) | [ ]  | Please, specify: |
| Recent laboratory test results | [ ]  | Please, indicate the time of your last blood and urine test: |
| Injuries, surgeries | [ ]  | Injuries:Surgeries: |

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| **5. Short questions related to nutrition**Please, mark the answers that are true for your nutrition below. |
| How often do you consume fruits and vegetables?  | Every day | Not every day | I don’t know |
| How many meals do you have per day? | [ ]  1[ ]  2[ ]  3[ ]  4[ ]  5[ ]  More than 5[ ]  I don’t know |
| Please, indicate your daily fluid intake (e.g. water, mineral water, tea, soup – please, don’t include alcoholic beverages and energy drinks). | [ ]  Less than 0.5 l[ ]  0,5 l - 1 l[ ]  1 l - 1,5 l[ ]  1,5 l - 2 l[ ]  2 l - 2,5 l [ ]  Between 2,5 l and 3 l[ ]  More than 3 l[ ]  I don’t know |
| Do you bake or cook? | YES | NO | If so, how often? |  |
| Are you currently on a diet? | YES | NO | Please, specify: |

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| **6. Short questions related to physical activity** |
| **What type of work do you do?** (office work, manual labour, etc.) |  |
| **How much time do you spend sitting on a typical day?** (This involves sitting at a desk, studying, watching television, etc.) |  |
| **What sports have you been doing?** (at an amateur and/or competitive level) | Sports | Duration | Level |
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| **6.1 Do you currently do any type of exercise and/or physical activity?**  | YES | NO | *If you answered ’YES’, please also answer the questions below.* |
| How often do you do exercise and/or physical activity per week? |  |
| On average, how much time do you spend doing exercise and/or physical activity per day? |  |
| What types of sports and/or exercise do you do? (e.g. running, swimming, aerobics, spinning, strength training) |  |

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| **7. Smoking** |
| Do you currently smoke?  | YES | NO | If you answered ’YES’, how long have you been smoking, and how much do you typically smoke per day? |

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| **8. Alcohol consumption** |
| Do you drink alcoholic beverages? | YES | NO | If you answered ’YES’, which frequency is true for you?[ ]  Four or more times per week[ ]  Two or three times per week[ ]  Once a week[ ]  Two or three times per month[ ]  Once a month or less |

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| 9. Sleeping |
| How many hours do you sleep on average a day? |  | What time do you usually get up? |  |
| When do you usually go to bed? |  |

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| **10. Other** |
| Why did you apply for the counselling? |  |
| Any other comments about your current lifestyle that may contribute to the effectiveness of the counselling (e.g. night shift work, regular travel, etc.): |  |