Lifestyle and Habits Survey for Critical Illness Evaluation

Personal Information

Full Name

Date of Birth

Gender

Select

Physical Activity

How often do you exercise per week?

Select

Describe your regular physical activities

Dietary Habits

How many servings of fruits and vegetables do you consume daily?

How often do you consume processed or fast food?

Select

Smoking & Alcohol Consumption

Do you currently smoke?

Select

If yes, how many cigarettes per day?

Do you consume alcohol?

Select

Sleep Pattern

Average hours of sleep per night

Do you have trouble sleeping or insomnia?

Select

Medical History

Have you ever been diagnosed with any chronic illnesses?

Family history of critical illnesses (e.g., cancer, heart disease, diabetes)

Additional Comments

Optional