**Health Risk Assessment (HRA) Form**

**Employee Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Employee Name:** | John Doe | **Employee ID:** | EMP-4587 |
| **Position/Title:** | Sales Associate | **Department:** | Sales |
| Date of Birth |  | Gender | ☐ Male ☐ Female ☐ Other |
| Date Completed |  |  |  |

**Section 1: General Health Information**

|  |  |
| --- | --- |
| **Question** | **Response Options** |
| 1. How would you describe your general health? | ☐ Excellent ☐ Good ☐ Fair ☐ Poor |
| 2. Do you have a regular family doctor or primary care physician? | ☐ Yes ☐ No |
| 3. How often do you get a medical check-up? | ☐ Annually ☐ Every 2–3 years ☐ Rarely ☐ Never |
| 4. Are you currently taking any prescribed medications? | ☐ Yes ☐ No — If yes, please list: |
| 5. Do you have any chronic conditions (e.g., diabetes, hypertension, asthma)? | ☐ Yes ☐ No — If yes, please specify: |

**Section 2: Lifestyle and Habits**

|  |  |
| --- | --- |
| **Question** | **Response Options** |
| 1. How often do you engage in physical activity (30+ minutes)? | ☐ Daily ☐ 3–5 days/week ☐ 1–2 days/week ☐ Rarely/Never |
| 2. Do you smoke or use tobacco products? | ☐ Yes ☐ No ☐ Occasionally |
| 3. How often do you consume alcohol? | ☐ Never ☐ Occasionally ☐ Weekly ☐ Daily |
| 4. How many servings of fruits and vegetables do you eat daily? | ☐ 0–1 ☐ 2–3 ☐ 4–5 ☐ 6+ |
| 5. Average daily sleep duration? | ☐ <5 hrs ☐ 5–6 hrs ☐ 7–8 hrs ☐ 9+ hrs |
| 6. Do you often feel stressed or anxious? | ☐ Never ☐ Sometimes ☐ Often ☐ Always |

**Section 3: Biometric Data (if available)**

|  |  |  |
| --- | --- | --- |
| **Parameter** | **Value** | **Reference Range** |
| Height (cm) |  | — |
| Weight (kg) |  | — |
| BMI (Auto Formula) |  | 18.5–24.9 |
| Blood Pressure (mmHg) |  | <120/80 |
| Blood Sugar (mg/dL) |  | 70–100 (fasting) |
| Cholesterol (mg/dL) |  | <200 |

**Section 4: Preventive Care**

|  |  |
| --- | --- |
| **Question** | **Response Options** |
| 1. Have you received your annual flu vaccine? | ☐ Yes ☐ No |
| 2. Have you had a dental check-up in the past 12 months? | ☐ Yes ☐ No |
| 3. Have you had an eye exam in the past 2 years? | ☐ Yes ☐ No |
| 4. Do you perform regular self-checks (e.g., blood pressure, skin, etc.)? | ☐ Yes ☐ No |
|  |  |
|  |  |

**Section 5: Stress and Mental Well-being**

|  |  |
| --- | --- |
| **Question** | **Response Options** |
| 1. How often do you feel fatigued or exhausted during work? | ☐ Rarely ☐ Sometimes ☐ Often |
| 2. Do you have someone to talk to when feeling stressed? | ☐ Yes ☐ No |
| 3. How would you rate your work-life balance? | ☐ Excellent ☐ Good ☐ Fair ☐ Poor |
|  |  |

**Section 6: Health Risk Summary (to be filled by Health Officer / HR)**

|  |  |  |
| --- | --- | --- |
| **Risk Area** | **Risk Level** | **Notes / Recommendations** |
| Physical Activity | ☐ Low ☐ Moderate ☐ High |  |
| Nutrition | ☐ Low ☐ Moderate ☐ High |  |
| Stress | ☐ Low ☐ Moderate ☐ High |  |
| Smoking / Alcohol | ☐ Low ☐ Moderate ☐ High |  |
| Overall Health Risk Score | **=AVERAGE(risk\_values)** |  |

**Section 7: Employee Acknowledgment**

I confirm that the information provided above is accurate to the best of my knowledge.

**Employee Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reviewed by (Health Officer / HR):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_