

IUNE 4D Longevity – Short Health Questionnaire

Name: _____
Passport number: _____
Date of birth: _____
Phone number: _____
Email address: _____
Address: _____

1. Do you currently have a medically diagnosed condition?

- No
 Yes, which one: _____

2. Which medications do you take regularly?

3. Which dietary supplements do you take regularly?

4. Have you had any surgeries or major injuries?

- No
 Yes, which ones & when: _____

5. Do you suffer from allergies or intolerances?

- No
 Yes, which ones: _____

6. Have you ever had any of the following infections?

(Multiple answers possible)

- EBV
- Lyme disease
- Covid-19
- Shingles
- Other: _____

7. Is there any known autoimmune disease?

- No
- Yes, which one: _____

8. How would you rate your current energy level?

(0 = no energy / 10 = full energy)

- 0 1 2 3 4 5 6 7 8 9 10

9. Do you regularly suffer from pain?

- No
- Yes, where: _____

10. Do you have problems with sleep or recovery?

- No
- Difficulty falling asleep
- Difficulty staying asleep
- Non-restorative sleep

11. How would you describe your digestion?

- Regular
- Irregular
- Bloating
- Diarrhea
- Constipation
- Other: _____

12. Do you have any cardiovascular complaints?

- No
- Palpitations

- Arrhythmias
- Chest pain
- Dizziness

13. Do you have any respiratory or lung conditions?

- No
- Asthma
- COPD
- Shortness of breath during exertion
- Other: _____

14. Have you experienced any significant weight changes in the last 5 years?

- No
- Weight gain: _____ kg
- Weight loss: _____ kg

15. How high is your current stress level?

(0 = no stress / 10 = maximum stress)

- 0 1 2 3 4 5 6 7 8 9 10

16. Do you exercise regularly?

- No
- Once per week
- 2–3 times per week
- More than 5 times per week

Type: _____

17. Do you smoke or consume alcohol?

- No
- Smoking: _____ per day
- Alcohol: _____ per week (type: _____)

18. Have there been any abnormal laboratory values in the past?

- No
- Yes, which ones: _____

19. Do you have any known hormonal changes or complaints?

- No
- Thyroid
- Menopause
- Andropause
- Libido
- Other: _____

20. What is your most important health goal?

Covid-19 Status

Infection:

- No
- Yes, when & symptoms: _____

Vaccination:

- No
- Yes

Vaccine: _____

Number of vaccinations: _____

Last vaccination on: _____

Vaccine reactions/complaints: _____

Signature, place and date