P3 Medical Group

*Built by **Doctors.** Loved by **Patients.***

Health History Questionnaire

Patient Name:_____ DOB: _____

Main reason for today's visit: _____

Other concerns:_____

_____

How would you rate your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Allergies (e.g. medication, food, other)

Item	Reaction (e.g. rash, swelling, etc.)

Medications

Medication Name	Dosage	Frequency Taken

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Over the Counter (OTC) Drugs/Supplements

Medication/Supplement Name	Dosage	Frequency Taken

Vaccination History

Vaccine	Date	Vaccine	Date
Flu		Zostavax (Shingles)	
Prevnar (1st series)		Shingrix (Shingles)	
Pneumovax (2nd series, 12 months later)		Hepatitis A	
MMR		Hepatitis B	
Tetanus		Gardasil (HPV)	
Tdap			

Family History (please mark all that apply)

Disorder	Mother	Father	Sibling Brother/Sister	Grandparent Paternal/Maternal	Aunt Paternal/Maternal	Uncle Paternal/Maternal
Alcoholism						
Arthritis						
Depression						
Diabetes						
Drug Abuse						
Cancer						
Hypertension						
Heart Disease						
Kidney Disease						
Mental Illness						
Stroke						
Thyroid Disease						
Other:						

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Social History

Tobacco Use: ☐ Never ☐ Former (Date Quit:_____) ☐ Current

Years of Use? _____ No. of Packs? _____ per Day / Month

Drug Use: ☐ Never ☐ Former (Date Quit:_____) ☐ Current

What drug(s)? _____

Years of Use? _____ How much? _____

Alcohol Use: ☐ Never ☐ Former (Date Quit:_____) ☐ Current

Years of Use? _____ No. of Drinks? _____ per Day / Month

History of Falls: (last 3 months) ☐ No falls ☐ 1-2 ☐ 3 or more

Do you exercise? (circle one) Yes No

Type of exercise? _____

How often? _____

Do you feel safe at home? _____ (Y/N)

What is the highest level of education you have completed? (circle one)

High School College Graduate School Post Graduate School

Do you have an advance directive (i.e. living will, power of attorney, trust)? _____ (Y/N)

If no, would you like to discuss obtaining one today? _____ (Y/N)

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Surgical History

Surgery	Date

Health Maintenance History

Test	Date	Results
Blood Tests		
Bone Density Scan		
Colonoscopy		
Eye Exam		
Mammogram		
PAP Smear		
Physical		

Functional Levels (Katz ADL) – Please mark the appropriate box

	No Assistance	Some Assistance	Full Assistance
Eating			
Bathing			
Dressing			
Toileting			
Transferring			
Maintaining Continence			
Handling Finances			
Medication Management			

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Past Medical History (please check all that apply)

Anemia		Diverticulosis		Kidney Disease	
Anxiety		Diverticulitis		Kidney Stones	
Arthritis		Emphysema		Liver Disease/Hepatitis	
Asthma		Gout		Migraines/Headache	
Bleeding Disorder		Heart Attack		Osteoporosis	
Blood Clots – Legs		Heart Failure		Pulmonary Embolism	
Cancer/Type:		Pacemaker		Seizures	
Colon Polyps		Heart Murmur		Stroke	
COPD		Hiatal Hernia/Acid Reflux		Thyroid Disorder	
Coronary Artery Disease		HIV/AIDS		Tuberculosis	
Dementia		High Cholesterol			
Depression		High Blood Pressure		Other:	
Diabetes		Irregular Heart rate (AFib)			

_____ _____

Patient Signature Date

_____ _____

Legal Guardian/Caregiver Signature Date

Patient Name:_____ DOB: _____