P3 Health Partners
People. Passion. Purpose.

Health History Questionnaire

Patient name: ____

Main reason for today's visit: ______________________________________

Other concerns: ____

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

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

Medications

Medication name	Dosage	Frequency taken

Patient Name____

Vaccination History

Vaccine	Date	Vaccine	Date
Flu		Zostavax (Shingles)	
Pneumovax (Pneumonia)		Prevnar	
Hepatitis A		Hepatitis B	
MMR		Tdap	
Tetanus		Gardasil/HPV	

Past Medical History – Please check all that apply

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

Surgical History

Surgery	Date

Patient Name____

Family History

Disorder	Mother	Father	Sibling	Sibling	Other
Alcoholism/Drug Use					
Arthritis					
Depression					
Diabetes					
Cancer					
Hypertension					
Heart Disease					
Stroke					
Mental Illness					
Other					

Social History

Have you ever used tobacco? (circle one) Yes No

If yes, how long and how much? ________________________________

Do you use any street drugs or marijuana? (circle one) Yes No

If yes, what are you using? ____________________________________

Do you drink alcohol? (circle one) YesNo

If yes, how much and how often?________________________________

What is your marital status? (circle one)

Single Domestic Partnership Married Divorced Widowed

Do you exercise? (circle one) Yes No

If yes, what do you do and how often? ___________________________

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

High School College Graduate School Post Graduate School

Patient Name____

Health Maintenance History

	Date of your most recent…	Results
Physical		
Mammogram (females)		
PAP smear(females)		
Bone density scan		
Blood tests		
Colonoscopy		
Chest X-ray		

Functional Levels

How much assistance do you need with the following?

	No assistance	Some assistance	Complete assistance
Eating			
Bathing			
Dressing			
Toileting			
Transferring			
Maintaining Continence			
Handling Finances			
Managing Medications			

Patient Name____

Review of Systems

Please check any of the following that apply to you

General		Nervous System		Psychiatric	
• Weight gain		• Headaches		• Depression	
• Weight loss		• Dizziness		• Anxiety	
• Fatigue		• Fainting/loss of Consciousness		• Mood Swings	
• Fever		• Numbness/tingling		**Ears**	
• Night sweats		• Memory loss		• Ringing in ears	
Muscle/Joints		**Gastrointestinal**		• Loss of hearing	
• Joint pain		• Nausea		**Eyes**	
• Muscle weakness		• Heartburn		• Eye pain	
• Joint swelling		• Vomiting		• Eye redness	
Throat		• Constipation		• Eye dryness	
• Sore throat		• Diarrhea		• Blurred vision/vision loss	
• Hoarseness		• Blood in stools		**Skin**	
• Difficulty swallowing		• Black stools		• Redness	
Heart/Lungs		**Urinary Tract**		• Rash	
• Chest pain		• Painful urination		• Hair loss	
• Palpitations		• Frequent urination		• Skin lesions	
• Shortness of breath		• Blood in urine		**Other**	
• Cough		**Women only**			
• Leg swelling		• Irregular periods			
		• Bleeding between periods			

Do you have an advance directive (i.e., living will, power of attorney, etc.)?

(circle one) Yes No

If not, would you like to discuss obtaining one today?

(circle one) Yes No

Is there anything else you would like your clinician to know?

______________________________ ________________

Patient Name (please print) Date of Birth

______________________________ ________________

Patient Signature Date

______________________________ ________________

Legal Guardian or Caregiver Signature Date