PRIVIA
MEDICAL GROUP

Patient Information

Last Name _____
First Name _____
Middle Name _____
Former Last Name _____
Sex _____
DOB _____
SSN _____
Address _____
Address 2 _____
Zip _____
City _____
State _____
Home phone _____
Mobile phone _____
Work phone _____
Email (required) _____
Preferred Pharmacy _____
Contact preference (please circle): HOME MOBILE WORK
Language _____
Race _____
Ethnicity _____
Marital Status _____
Homebound? YES NO

How did you hear about us? **(please circle options below)**

Advertising Primary Care Physician Specialist Physician Word of Mouth

Insurance Patient in Practice Hospital Insurance Co. Other

Specify (if Other, above) _____

Today's Date _____

Guardian

Last Name _____
First Name _____
Middle name _____

Emergency Contact

Name _____
Relationship _____
Home phone _____
Mobile phone _____

Next of Kin

Name _____
Relationship _____
Phone _____

Employment

Employer name _____
Employer phone _____

Guarantor Information

Last Name _____
First Name _____
Middle name _____
DOB _____
Address _____
Address 2 _____
Zip _____
City _____
State _____

Optional Information

Phone _____

Primary Insurance Information

Insurance Plan Name _____

ID/Certification No. _____

Policy/Group No. _____

Secondary Insurance Information

Insurance Plan Name _____

ID/Certification No. _____

Policy/Group No. _____

Primary Policy Holder (if other than patient)

Patient's Relationship to policy holder: _____

Last Name _____

First Name _____

Middle Name _____

Address _____

Address (ctd) _____

City _____

State _____

Zip _____

Date of Birth _____

Policy Holder Sex _____

Employer Name _____

Secondary Policy Holder (if other than patient)

Patient's Relationship to policy holder: _____

Last Name _____

First Name _____

Middle Name _____

Address _____

Address (ctd) _____

City _____

State _____

Zip _____

Date of Birth _____

Policy Holder Sex _____

Employer Name _____

Patient Signature: _____ **Date:** _____

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1. _____	_____
2. _____	_____
3. _____	_____

FAVORITE PHARMACY

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

☐ Chickenpox	Date:_____	☐ Meningococcus	Date:_____
☐ Flu Shot	Date:_____	☐ MMR *(Measles, Mumps, Rubella)*	Date:_____
☐ Gardasil/HPV	Date:_____	☐ Pneumonia	Date:_____
☐ Hepatitis A	Date:_____	☐ Tdap *(Tetanus and pertussis)*	Date:_____
☐ Hepatitis B	Date:_____	☐ Tetanus	Date:_____
		☐ Zostavax *(Shingles)*	Date:_____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ ☐ Abnormal

Last Mammogram Date _____ ☐ Abnormal

Age of first menstrual period: _____

Date of last menstrual period or age of menopause: _____

Number of pregnancies: _____ births: _____

miscarriages: _____ abortions: _____

☐ Cesarean sections If yes, then number: _____

☐ Bleeding between periods
☐ Heavy periods
☐ Extreme menstrual pain
☐ Vaginal itching, burning, or discharge
☐ Wake in the night to go to the bathroom
☐ Hot flashes
☐ Breast lump or nipple discharge
☐ Painful intercourse
☐ Sexually active

Current sexual partner is ☐ Female ☐ Male

Do you use condoms ☐ Yes ☐ No

Other Birth control method used: _____

☐ Interested in being screened for STDs