Seasons OBSTETRICS & GYNECOLOGY

Confidential Health History

Updated 9/24/2019

Name	Age	Date of Birth	Today's Date
Primary Phone Number	E-mail Address		
Referring Physician / Person	Primary Care Provider		
Preferred Pharmacy Name	Pharmacy Phone Number		
Pharmacy Address	Pharmacy Cross Streets		
Reason for visit			

PREVENTIVE HEALTH

	Date of last		Date of last		Date of last
Pap		Blood Work		Bone Density	
Mammogram		Colonoscopy			
History of abnormal pap?	☐ Yes ☐ No	Would you accept blood products?	☐ Yes ☐ No		

MEDICAL HISTORY

Please check any past or current medical problems for yourself or immediate, blood relatives

X = Yourself; M = Mother; F = Father; S = Sister; B = Brother; Maternal Grandparents = MGM or MGF; Paternal Grandparents = PGM or PGF

	You	Family		You	Family
Autoimmune Disease (Lupus, MS, etc.)			Heart Disease		
Alzheimer's			Hemorrhoids		
Anemia			Hepatitis		
Arthritis			High Blood Pressure		
Bleeding Disorder			Irritable Bowel Syndrome		
Blood Clots in legs			Kidney Disease		
Blood Clots in lungs			Lung Disease, Asthma		
Blood Disorders			Mental Illness, Depression		
Cancer Breast			Migraine Headache		
Cancer Colon			Osteoporosis		
Cancer Ovarian			Seizure Disorder		
Cancers Other			Skin Disorders		
Diabetes			Stroke		
Drug/Alcohol Abuse			Thyroid Disorder		
Frequent Bladder Infections			Tuberculosis		
Gallbladder Disease or Gallstones			Ulcers		
Hearing Problems			Other		

SURGERIES

Date	Surgery	Date	Surgery

CURRENT MEDICATION

List any MEDICATIONS you are taking, to include birth control pills, Tylenol, Advil, Aspirin, other non-prescription medicine, vitamins, herbs.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Do you take Calcium?	☐ Yes	☐ No	If yes, amount
Do you take Vitamin D?	☐ Yes	☐ No	If yes, amount
Do you take Multiple Vitamin or Prenatal Vitamin?	☐ Yes	☐ No	

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MEDICATION ALLERGIES

Do you have any medication allergies?	☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?

FOOD ALLERGIES

Do you have any food allergies?	☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?

ENVIRONMENTAL / LATEX ALLERGIES

Do you have any environmental / latex allergies?	☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?

MENSTRUAL HISTORY

First day of last normal menstrual period - Date	Is menstrual pain or cramping a problem for you? ☐ Yes ☐ No
Age period began	Do you ever have spotting or bleeding in between your periods? ☐ Yes ☐ No
Number of days between periods	
Length of periods (# of days of bleeding)	Is PMS a problem for you? ☐ Yes ☐ No
Menstrual flow: ☐ Light ☐ Medium ☐ Heavy	Do you perform self-breast exams? ☐ Yes ☐ No

How often do you change pads / tampons on your heaviest day of menses? Every ________ hours

Do your periods regularly affect your life in a negative way? ☐ Yes ☐ No

Method of birth control

☐ Condoms	☐ Diaphragm	☐ Implanon	☐ Nuva Ring	☐ Post Menopause	☐ Vasectomy
☐ Contraceptive Pills	☐ Essure	☐ IUD	☐ Foam, Jelly, etc.	☐ Same Sex Partner	☐ Other:
☐ Depo Provera	☐ Hystectomy	☐ Not Sexually Active	☐ Patch	☐ Tubal Ligation	☐ None

Are you interested in a different method of birth control? ☐ Yes ☐ No

REPRODUCTIVE PREGNANCY HISTORY

# of times pregnant	# of term deliveries	# of deliveries prior to 37 weeks	# of elective abortions
# of miscarriages	# of ectopic pregnancies	# of multiple births	# of living children

PREGNANCY DETAILS #1

	Type of delivery	Complications
Date	☐ Vaginal	
# weeks at delivery	☐ C-section	
Birth weight	☐ Elective abortion	
Sex of child	☐ Miscarriage	
Name		

PREGNANCY DETAILS #2

	Type of delivery	Complications
Date	☐ Vaginal	
# weeks at delivery	☐ C-section	
Birth weight	☐ Elective abortion	
Sex of child	☐ Miscarriage	
Name		

PREGNANCY DETAILS #3

	Type of delivery	Complications
Date	☐ Vaginal	
# weeks at delivery	☐ C-section	
Birth weight	☐ Elective abortion	
Sex of child	☐ Miscarriage	
Name		

PREGNANCY DETAILS #4

	Type of delivery	Complications
Date	☐ Vaginal	
# weeks at delivery	☐ C-section	
Birth weight	☐ Elective abortion	
Sex of child	☐ Miscarriage	
Name		

SOCIAL HISTORY

Marital Status ☐ Divorced ☐ Engaged ☐ Married ☐ Partnered ☐ Separated ☐ Single ☐ Widowed

Race ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other

Patient Occupation	Husband / Partner's Occupation

Do you exercise?	☐ Yes ☐ No	If yes, # of times per week		Number of children living at home
Do you / did you ever drink alcohol?	☐ Yes ☐ No	How much per week?	How many drinks a day?	Is alcohol or drug use a problem for you? ☐ Yes ☐ No
Do you / did you ever use tobacco?	☐ Yes ☐ No	If yes, what type? ☐ Chewing Tobacco	☐ Smoking/Cigarettes	How many years? / How much per day? / When did you stop?

Do you / did you ever use any recreational drugs or abuse prescription drugs?	☐ Yes ☐ No	If yes, what type?
Have you ever been sexually abused?	☐ Yes ☐ No	If you have experienced abuse, have you received counseling? ☐ Yes ☐ No
Have you ever been physically abused?	☐ Yes ☐ No	
Have you ever been emotionally abused by anyone important to you?	☐ Yes ☐ No	Is this something you would like to discuss today? ☐ Yes ☐ No

Seasons OBSTETRICS & GYNECOLOGY

Confidential Health History

Name	Date of Birth	Today's Date

REPRODUCTIVE PREGNANCY HISTORY (continued)

PREGNANCY DETAILS #5

	Type of delivery	Complications
Date	☐ Vaginal	
# weeks at delivery	☐ C-section	
Birth weight	☐ Elective abortion	
Sex of child	☐ Miscarriage	
Name		

PREGNANCY DETAILS #6

	Type of delivery	Complications
Date	☐ Vaginal	
# weeks at delivery	☐ C-section	
Birth weight	☐ Elective abortion	
Sex of child	☐ Miscarriage	
Name		

PREGNANCY DETAILS #7

	Type of delivery	Complications
Date	☐ Vaginal	
# weeks at delivery	☐ C-section	
Birth weight	☐ Elective abortion	
Sex of child	☐ Miscarriage	
Name		

PREGNANCY DETAILS #8

	Type of delivery	Complications
Date	☐ Vaginal	
# weeks at delivery	☐ C-section	
Birth weight	☐ Elective abortion	
Sex of child	☐ Miscarriage	
Name		

PREGNANCY DETAILS #9

	Type of delivery	Complications
Date	☐ Vaginal	
# weeks at delivery	☐ C-section	
Birth weight	☐ Elective abortion	
Sex of child	☐ Miscarriage	
Name		

PREGNANCY DETAILS #10

	Type of delivery	Complications
Date	☐ Vaginal	
# weeks at delivery	☐ C-section	
Birth weight	☐ Elective abortion	
Sex of child	☐ Miscarriage	
Name		

PREGNANCY DETAILS #11

	Type of delivery	Complications
Date	☐ Vaginal	
# weeks at delivery	☐ C-section	
Birth weight	☐ Elective abortion	
Sex of child	☐ Miscarriage	
Name		

PREGNANCY DETAILS #12

	Type of delivery	Complications
Date	☐ Vaginal	
# weeks at delivery	☐ C-section	
Birth weight	☐ Elective abortion	
Sex of child	☐ Miscarriage	
Name		

Seasons
OBSTETRICS
& GYNECOLOGY

Patient Name: ______________________ **Date of Birth:** ______________

BMI Screening: When your Height and Weight are entered into our Electronic Health Record, your Body Mass Index (BMI) is calculated automatically. If your BMI is considered above or below normal, we are required to give you information pertaining to a healthy lifestyle of diet and/or exercise. Please visit the Center for Disease Controls website for more information visit: http://www.cdc.gov/healthyweight/assessing/adultbmi/index.html

Pneumonia Vaccination Status: If you are 65 years of age or older, it is recommended that you get a Pneumococcal vaccination.

Have you had a Pneumonia Vaccination? Yes/No Approximate Date of your last vaccination?

If not, please talk with your Primary Care Physician about getting one. For more information on the Pneumococcal vaccine please visit the Center for Disease Control's website at:
http://www.cdc.gov/VACCINES/vpd-vac/pneumo/default.htm

Breast Cancer Screening: If you are a female 40-69 years of age, it is recommended that you get regular screenings for breast cancer. Although it is not necessarily related to your visit at our office, we are being required to ask if you have had these screening tests.

Have you had a mammogram? Yes/No Approximate date of your last mammogram: ____________

If not, please talk to your Primary Care Physician or Gynecologist about ordering a mammogram. For more information on mammograms, please visit the American Cancer Society's website at: www.cancer.org

Colorectal Cancer Screening: If you are 50-75 years of age, it is recommended that you get regular screenings for colorectal cancer. Although it is not necessarily related to your visit at our office, we are being required to ask if you have had your screening test(s).

Have you had a colonoscopy? Yes/No Approximate date of your last colonoscopy: ____________

If not, please talk to your Primary Care Physician about ordering a colonoscopy. For more information on colonoscopies, please visit the American Cancer Society's website at: www.cancer.org

Tobacco Use: If you are 18 years or older: Have you **ever** used any type of tobacco product (including smokeless products)?

Please circle: **NEVER** **CURRENT** **FORMER**

If **NEVER**, you are finished.
If CURRENT or FORMER, please answer the following questions to the best of your abilities:

1. Type of tobacco used: ______________________________
2. How much per day: ______________________________
3. Approximate age started: ______________________________
4. Have you ever tried to stop? ________ If yes, approximate age: ______________
5. What method did you use to try to stop (if applicable): ______________________
6. Approximate age stopped successfully (if applicable): ______________________

Please visit the Center for Disease Control's website for additional information onTobacco cessation at: www.cdc.gov/tobacco

Seasons
OBSTETRICS
& GYNECOLOGY

Patient Name: ______________________________ **Date of Birth:** __________________________

PATIENT HEALTH QUESTIONNAIRE (PHQ9)

Use ✓ to indicate your answer

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than ½ the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching T.V.				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in someway				
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?				

Future Fall Risk and Plan of Care: If you are 65 years of age or older, it is recommended that you complete a fall risk assessment.

Have you had a fall(s) in the last year? Yes/No
If you answered yes , how many? ________________ Did the fall(s) result in an injury? Yes/No

Please visit the American Geriatric's website for additional information to Fall Risk Assessment at www.americangeriatrics.org

MYRIAD myRisk Hereditary Cancer

Cancer Family History Questionnaire

Personal Information

Patient Name		Date of Birth		Healthcare Provider		Today's Date	

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know.
The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

Do you have a personal history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, **ovarian**, or **pancreatic cancer** at any age	☐Y ☐N		
Colorectal or **uterine cancer** at 64 or younger	☐Y ☐N		

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	☐Y ☐N		☐M ☐P	
Two **breast cancers** (bilateral) in one relative at any age	☐Y ☐N		☐M ☐P	
Three **breast cancers** in relatives on the same side of the family at any age	☐Y ☐N		☐M ☐P	
Ovarian cancer at any age	☐Y ☐N		☐M ☐P	
Pancreatic cancer at any age	☐Y ☐N		☐M ☐P	
Male breast cancer at any age	☐Y ☐N		☐M ☐P	
Metastatic prostate cancer at any age	☐Y ☐N		☐M ☐P	
Colon cancer at 49 or younger	☐Y ☐N		☐M ☐P	
Uterine cancer at 49 or younger	☐Y ☐N		☐M ☐P	
Ashkenazi Jewish ancestry with **breast cancer** at any age	☐Y ☐N		☐M ☐P	
Do you have a family history of **other cancers**?	☐Y ☐N	List them here:		
Have you or anyone in your family had genetic testing for hereditary cancer?	☐Y ☐N	Who?	What gene(s)?	What was the result?

Cancer Risk Assessment Review (to be completed after discussion with your healthcare provider)

Patient Signature____________________ Date __________

Healthcare Provider Signature____________________ Date__________

Office Use Only Patient offered hereditary cancer genetic testing? ☐Yes ☐No ☐Accepted ☐Declined

If yes, which test? ☐BRAC*Analysis*® with Myriad myRisk® Multisite 3 BRAC*Analysis*® REFLEX to BRAC*Analysis*® with Myriad myRisk® ☐COLARIS®PLUS with Myriad myRisk® ☐COLARIS *AP*®PLUS with Myriad myRisk® ☐Single Site Testing ☐Myriad myRisk® Update ☐Other: __________

Follow-up appointment scheduled? ☐Yes ☐No Date of next appointment:__________

PRIVIA MEDICAL GROUP NORTH TEXAS

PHYSICIAN: ______________________ BEING SEEN TODAY

LOCATION: ______________ DATE: ____________

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: ____________________ Driver's License # ____________________ State: __________

Name: ______________________________________ ____ ____ MM/DD/YY ___/___/___ ____ S M D W O
LAST FIRST MI SEX DATE OF BIRTH AGE MARITAL STATUS

Address: ______________________________ ______________ ____ ______ (____) ____________
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Alt/Cell Phone: (____)______________ Day Phone: (____)______________ Email: ______________

Race______________ Language______________ Ethnicity ☐ Hispanic/Latin ☐ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student
EMPLOYMENT STATUS (PLEASE CIRCLE ONE)

Employer's Name: or School ______________________________

Employer's Address: ______________________________ ______________ ____ ______
MAILING ADDRESS CITY ST ZIP

Occupation: ______________________________

Emergency Contact: *(Please indicate a friend or relative not living at the same address.)*

______________________________ ______________ (____)______________
NAME RELATIONSHIP EMERGENCY CONTACT #

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child ____ Other ______________ Resp. Party SS #: ______________
SPECIFY

Name: ______________________________________ ____ ____ MM/DD/YY ___/___/___ ____ S M D W O
LAST FIRST MI SEX DATE OF BIRTH AGE MARITAL STATUS

Address: ______________________________ ______________ ____ ______ (____) ____________
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Full-Time Part-Time Retired Unemployed Student
EMPLOYMENT STATUS (PLEASE CIRCLE ONE)

Employer's Name: or School ______________________________

Employer's Address: ______________________________ ______________ ____ ______
MAILING ADDRESS CITY ST ZIP

Occupation: ______________________________ (____)______________ (____)
WORK PHONE EXT

OTHER PATIENT INFORMATION

Spouse's Name: ______________________________ Employer: ______________________________

___/___/___ Spouse's Work Phone: (____) ______________ (____) Occupation: ______________
DATE OF BIRTH EXT

PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: ______________________________ Address: ______________________ (____) ____________
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) ______________ ______________ ____ ______
CITY ST ZIP

Primary Care Physician: ______________________________

Policy Holder: ______________________________________ ____ ____ ___/___/___ ____________
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other______________
(SPECIFY)

Employer's Name: ______________________________ ______________ ______________
INSUREDS ID GROUP NAME AND/OR NUMBER

Address: ______________________________ ______________ ____ ______
STREET CITY ST ZIP

THC99P02

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: ______________________ Address: ______________________ (____) __________
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) ______________________ ______________ ____ ______
CITY ST ZIP

Primary Care Physician: ______________________

Policy Holder: ______________________ ____ ____ ___/___/___ __________
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other__________
(SPECIFY)

Employer's Name: ______________________ ______________ ______________
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: ______________________ ______________ ____ ______
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: ______________________ Adj. __________

Address: ______________ City: ________ State ________ Zip ________ Phone __________

Claim #: ______________________ DOI ______________________

What Employer: ______________________

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident______________ Have you reported this injury to your employer? ___Yes ___No When __________

Describe accident briefly: ______________________

Do you have an attorney representing you? ___Yes ___No Who is the attorney? ______________

REFERRAL INFORMATION

Who referred you? ______________ Address: ______________ Phone: __________

Family Physician ______________ Address: ______________ Phone: __________

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Privia Medical Group North Texas (PMG), and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that PMG has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to PMG, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint PMG to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

______________________ ________ ______________________ ________
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE

Privia Medical Group North Texas

HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: ______________________
  - ☐ OK to leave a message with detailed information
  - ☐ Leave name and doctor with call back number only
- ☐ Work Telephone: ______________________
  - ☐ OK to leave message with detailed information
  - ☐ Leave name & doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address.
- ☐ Other: ______________________

I consent and authorize the release of NORMAL test results to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: ______________________
- ☐ My children: ______________________
- ☐ My parents: ______________________
- ☐ Other: ______________________

I consent and authorize the release of ABNORMAL test results to the following:

- ☐ Only myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: ______________________
- ☐ My children: ______________________
- ☐ My parents: ______________________
- ☐ Other: ______________________

I consent and authorize your office or a facility on my behalf, to conduct benefit verification services.

☐ Yes ☐ No

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

☐ Yes ☐ No

Do you have an advanced directive (Living Will)?

☐ Yes ☐ No

I consent and authorize your office or facility to make calls and/or send text messages containing important information about my account including marketing information and past-due notifications through an automated telephone dialing system.

☐ Yes ☐ No

____

Patient Signature (Must be an adult 18 yrs or older) Date

____

Print Name Birthdate

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____

Signature of Patient or Personal Representative

____

Date

____

Name of Patient or Personal Representative

____

Description of Personal Representative's Authority

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. Lungren/Osborn, with Privia Medical Group North Texas unless revoked by me in writing.

____

Patient Name/Legal Representative

____

Date of Birth

____

Date