



PATIENT DEMOGRAPHICS

Nuvia Health

Patient Information

Last Name:

First Name:

M.I.

Preferred Name

Date of Birth

Address:

City:

State:

Zip:

Contact Information

Phone:

Is this a mobile number? Yes No

Do you consent to receive text messages from Nuvia Health regarding appointments, care coordination, and practice-related communications at this number?

Yes No

Message and data rates may apply. You may opt out at any time by notifying the office.

Email Address:

Do you consent to receive non-urgent communications from Nuvia Health at this email address (e.g., scheduling, forms, general updates)?

Yes No

Gender & Identity

Sex Assigned at Birth:



Female Male Prefer not to answer

Pronouns (optional)

Preferred Language

Insurance — Primary

Carrier Name

Group Number

ID Number

Relationship to Subscriber

Subscriber Name (if not self)

Subscriber DOB

Subscriber Address (if not self): _____

Insurance — Secondary (if applicable)

Carrier Name

Group Number

ID Number

Relationship to Subscriber

Pharmacy

Pharmacy Name: _____

Pharmacy Address: _____

Do you authorize Nuvia Health to electronically send prescriptions?



Yes No

Emergency Contact

Name:

Phone:

Relationship to Patient:

This individual will only be contacted in the event of an emergency and is not authorized to receive medical information unless otherwise permitted by law.

Patient Signature

Date

By signing, I acknowledge the accuracy of the information provided above.



HEALTH HISTORY FORM

Full Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Allergies (medications, food, environmental, etc.): _____

Family & Personal Health History

Check all conditions that apply to you or your immediate family members.

Condition	Self	Mom	Dad	Sister	Brother	GM	GF
Alcohol/Drug Abuse							
Anemia							
Anxiety							
Arthritis							
Asthma							
Bipolar Disorder							
Cancer (Type: ___)							
Cataracts							
Chronic Bronchitis							
Crohn's Disease							
Depression							
Diabetes — Type 1							
Diabetes — Type 2							
Emphysema/COPD							
Endometriosis							
Esophageal Reflux/GERD							
Hearing Problems							
Heart Attack							
Heart Disease							
High Blood Pressure							
High Cholesterol							
Irritable Bowel Syndrome							
Kidney Disease							
Leukemia							
Migraine Headaches							
Neurological Disease							



HEALTH HISTORY FORM

Condition	Self	Mom	Dad	Sister	Brother	GM	GF
Osteoporosis							
Peptic Ulcer							
Schizophrenia							
Sexually Transmitted Infection							
Stroke							
Thyroid Disease (Hypo/Hyper)							
Tuberculosis							
Ulcerative Colitis							
Other:							



HEALTH HISTORY FORM

Hospitalizations & Surgeries

Hospitalization / Surgery	Reason	Year

Current Medications

Include prescription medications, over-the-counter drugs, vitamins, and supplements.

Medication	Dose	How Often	How Long

Healthcare Screenings

Healthcare Screening / Treatment	Date of Last
Routine Physical Exam	
Routine Eye Exam	
Stool Occult Blood Test	
Electrocardiogram (EKG)	
Cardiac Stress Test	
Sigmoidoscopy	
Colonoscopy	



HEALTH HISTORY FORM

Healthcare Screening / Treatment	Date of Last
Bone Density Scan	
Tetanus Injection	
Pneumonia Injection	
TB Skin Test	
Mammogram	
PAP Smear	



HEALTH HISTORY FORM

Habits & Lifestyle

Do you use any form of tobacco? Yes No

If yes, type and amount: _____

Do you drink alcoholic beverages? Yes No

If yes, type and amount: _____

Do you use recreational drugs or have a history of substance abuse? Yes No

If yes, details: _____

Are you sexually active? Yes No

Do you exercise regularly? Yes No

If yes, type and frequency: _____

Do you follow any special diet? Yes No

If yes, describe: _____

Female Patients Only

Age Menses Began: _____ Regular Menses: Yes No Last Menstrual Period:

Last Mammogram: _____ Last PAP: _____ OB/GYN: _____

of Pregnancies: _____ Live Births: _____ Form of Birth Control:

Are you currently pregnant or think you may be pregnant? Yes No

I certify that the above information is correct and true to the best of my knowledge. I will not hold my provider or any members of their staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature

Date



PATIENT HEALTH QUESTIONNAIRE

Name: _____ **Date of Birth:** _____ **Provider:** _____ **Date:** _____

Part of routine screening for your health includes reviewing mood and emotional concerns. Please answer each question as honestly as possible.

PHQ-2 Screening

During the past two weeks, have you often been bothered by the following problems?

1. Feeling down, depressed, irritable, or hopeless? Yes No
2. Little interest or pleasure in doing things? Yes No

If you answered “Yes” to either question above, please complete the PHQ-9 below.

PHQ-9 Assessment

Over the past 2 weeks, how often have you been bothered by the following problems?	Not at All (0)	Several Days (1)	More Than Half the Days (2)	Nearly Every Day (3)
1. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, irritable, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Poor appetite, weight loss, or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself — or feeling you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, like reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



PATIENT HEALTH QUESTIONNAIRE

Over the past 2 weeks, how often have you been bothered by the following problems?	Not at All (0)	Several Days (1)	More Than Half the Days (2)	Nearly Every Day (3)
more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home, or get along with others?

Not difficult at all
 Somewhat difficult
 Very difficult
 Extremely difficult

For Office Use Only – Total Score:	
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PHQ-2 and PHQ-9 adapted tool