

MORNING STAR OB/GYN

3011 S. LINDSAY ROAD, STE 113, GILBERT, AZ 85296, Tel: 480-355-8525 Fax: 480-355-3115

PATIENT INFORMATION

Patient Name: _____
Appointment Date: _____ Time: _____ Provider: _____

Mailing Address: _____ Apt/Ste: _____

City, State & ZIP: _____

Street Address (if different than mailing): _____

Home Phone: _____ Can we leave a message at home? (please circle) Y N

Cell Phone: _____ Can we leave a message on cell phone? (please circle) Y N

Employer Name: _____ Address: _____

Work Phone: _____ Can we leave a message at work? (please circle) Y N

Date of Birth: _____ Marital Status: _____

Social Security Number: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____

Pharmacy Name: _____ Phone: _____ Fax: _____

Address (cross streets & city are sufficient): _____

PAYMENT INFORMATION

Guarantor Name: _____ Relationship to Patient: _____

Address: _____

Gender: (please circle) M F Social Security Number: _____ Date of Birth: _____

Guarantor's Employer Name: _____ Work Phone: _____

Work Address: _____

Primary Insurance: _____

Address: _____ Insured Relationship to Pt: _____

Insured Name: _____ Date Of Birth: _____

Subscriber ID: _____ Group Number: _____

Secondary Insurance: _____

Address: _____ Insured Relationship to Pt: _____

Insured Name: _____ Date Of Birth: _____

Subscriber ID: _____ Group Number: _____

Medigap? _____ Supplemental? _____

How did you hear about us? _____

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Morning Star OB/GYN for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. **I understand that co-pays, co-insurance, deductibles and non-covered services are due at the time of service.**

Signature of Responsible Party: _____ Date: _____

Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: _____ Date: _____

MEDICAL INFORMATION

What is the reason for your visit today? _____

Do you have any other special concerns you would like the doctor to address? _____

Medications

Please list all medication you are taking and the dosages: _____

Please list any supplements or herbal medications that you take: _____

Allergies

Please list any allergies to medicine or food: _____

Past Medical History

| | Yes | No | Year/Description |
|------------------------------------|-------|-------|------------------|
| High Blood Pressure | _____ | _____ | _____ |
| Heart Disease | _____ | _____ | _____ |
| Autoimmune Disorder (Lupus) | _____ | _____ | _____ |
| Kidney Disease/Infection | _____ | _____ | _____ |
| Seizures/Other Neurologic Disorder | _____ | _____ | _____ |
| Depression/Postpartum Depression | _____ | _____ | _____ |
| Hepatitis/Liver Disease | _____ | _____ | _____ |
| Clots in Legs/Lungs | _____ | _____ | _____ |
| Thyroid Disease | _____ | _____ | _____ |
| Trauma/Violence | _____ | _____ | _____ |
| History of Blood Transfusion | _____ | _____ | _____ |
| Rh (D) Sensitized | _____ | _____ | _____ |
| Asthma | _____ | _____ | _____ |
| TB/Other Lung Disease | _____ | _____ | _____ |
| Seasonal Allergies | _____ | _____ | _____ |
| Breast Cancer | _____ | _____ | _____ |
| Diabetes | _____ | _____ | _____ |

Have you ever had chickenpox? (please circle) Y N

Are your immunizations up-to-date? (please circle) Y N Date of last tetanus: _____

Past Surgical History

Please list any surgeries that you have had:

| Year | Surgery |
|-------|---------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Besides pregnancy and these surgeries, have you ever been hospitalized for any other reason?

Family History

Have your parents, siblings or children had the following:

| | Yes | No | Relation |
|-------------------------|-------|-------|----------|
| Breast Cancer | _____ | _____ | _____ |
| Colon Cancer | _____ | _____ | _____ |
| Ovarian Cancer | _____ | _____ | _____ |
| Uterine Cancer | _____ | _____ | _____ |
| Recurrent miscarriage | _____ | _____ | _____ |
| Infertility | _____ | _____ | _____ |
| Diabetes | _____ | _____ | _____ |
| Endometriosis | _____ | _____ | _____ |
| Fibroids | _____ | _____ | _____ |
| Heart Disease | _____ | _____ | _____ |
| Kidney Disease | _____ | _____ | _____ |
| Depression | _____ | _____ | _____ |
| Other (Please explain): | _____ | _____ | _____ |

Social History

Do you smoke? (please circle) Y N Have you ever smoked? (please circle) Y N

If so, how much? _____ For how long? _____

Do you drink alcohol? (please circle) Y N How much? _____ How often? _____

Do you or have you ever used recreational drugs? (please circle) Y N Please describe: _____

Do you exercise regularly: (please circle) Y N What type? _____ How often? _____

What is your average intake of caffeine daily (coffee, tea, soda)? _____

What is your religious preference? _____

Gynecology History

What was the first day of your last period? _____

At what age did your menstrual periods begin? _____

How often do you have your period (every how many days)? _____

How long do you flow? _____ How would you describe the flow? (please circle) light medium heavy

Do you have severe pain with your periods? _____

Any abnormal bleeding? Please describe: _____

Do you have any pre-menstrual symptoms? (please circle) Y N

Please list: _____

Do you have symptoms of menopause? _____

Are you sexually active? _____ How many partners have you had in the last 12 months? _____

Do you have pain or bleeding with intercourse? _____

Do you have sexual difficulty/discomfort in your relationship? _____

When was your last Pap smear? _____ What was the result? _____

Have you ever had an abnormal Pap smear: (please circle) Y N If so, when? _____

If so, what was the method of treatment? _____

Review of Systems

Please check those problems which apply to you:

GENERAL

Fatigue ____
Weight gain ____
Weight loss ____
Fever ____
Hot flashes ____

ENDOCRINE

Sensitivity to hot ____
Sensitivity to cold ____
Excessive thirst ____
Abnormal hair growth ____
Hair loss ____

NEURO

Headaches ____
Seizures ____
Loss of strength ____
Loss of sensation ____

SKIN

Rash ____
Moles (growth/change) ____
Acne ____

EYES

Visual changes ____
Seeing spots or lights ____

ENT

Sore Throat ____
Nasal congestion ____

RESPIRATORY

Cough ____
Difficulty breathing ____

HEART

Chest pain ____
Palpitations ____

BREASTS

Breastfeeding ____
Mass or lump ____
Nipple discharge ____
Breast tenderness ____
Perform self breast exam ____
Other _____

GASTROINTESTINAL

Abdominal pain ____
Nausea ____
Vomiting ____
Diarrhea ____
Constipation ____
Heartburn ____
Blood in stool ____

GYN

Vaginal discharge ____
Vaginal burning/pain ____
Vaginal bulge ____
Vaginal/vulvar itching ____
Pelvic pain/pressure ____
Abnormal bleeding ____
Other _____

UROLOGY

Painful/burning urination ____
Blood in urine ____
Leakage or loss of urine ____

MUSCULOSKELETAL

Muscle pain ____
Joint pain ____
Joint swelling ____

MOOD

Depressed ____
Anxiety ____
Mood swings ____

HEMATOLOGY

Easy bruising ____
Frequent nosebleeds ____

This information is correct and has been completed to the best of my knowledge.

Patient Signature

Date