MORNING STAR OB/GYN

3499 S. MERCY ROAD, GILBERT, AZ 85297, Tel: 480-355-8525 Fax: 480-355-3115

Patient Name: _____ **Marital Status:** _____
Date of Birth:_____ **Appointment Date:** _____ **Time:** _____ **Provider:** _____

Mailing Address: _____ **Apt/Ste**: _____
City, State & ZIP: _____ **SSN:** _____
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

Please rank as 1st, 2nd, and 3rd; your preference for our communications with you in the future:

____ Text Message **____ Phone Call** **____ Secure Web Portal (provide e-mail):** _____

I consent to receive calls, text messages, or emails from Morning Star OB/GYN for my protected healthcare and other services at the phone number(s) listed above, as indicated by circling the Y. I understand that such calls may be generated by an automated dialing system and that such calls to my cell phone may result in charges by my wireless carrier. I realize that consent is not required as a condition of being a patient and that I may revoke this authorization at any time and that the revocation does not have to be in writing.

Signature of Responsible Party: _____ Date: _____

What is your race? (please circle) American Indian or Alaskan Native Asian Native Hawaiian or other Pacific Islander Black or African American White Hispanic Other _____ Other Pacific Islander Decline To Answer

What is your ethnicity? Hispanic or Latino **Preferred Language?** _____
Non-Hispanic or Latino Decline to Answer

Pharmacy Name: _____ **City:** _____ **Cross Streets:** _____

Employer Name: _____ **Address:** _____
Work Phone: _____ **Can we leave a message at your work?** Y N
Do you have an Advance Directive or a Living Will? (please circle) Y N

Emergency Contact Name: _____ **Relationship:** _____
Phone Number: _____
Primary Care Physician: _____ **City** _____ **Phone** _____

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:** _____

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. I also understand that any lab services such as blood work, cultures, and Pap smears are additional charges dependent on and invoiced by the lab vendor.**

Signature of Responsible Party: _____ Date: _____

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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? _____

_____

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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? _____

Have you ever been treated for:

____genital herpes ____genital warts ____chlamydia ____syphilis

____gonorrhea ____other sexually transmitted diseases (Describe: _____)

When was your last mammogram? _____ Where was it done? _____

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

Have you ever had a biopsy of the breast performed? _____ What was the result? _____

Have you ever had fibroid tumors? (please circle) Y N Ovarian cysts? (please circle) Y N

Have you ever been concerned about infertility? (please circle) Y N

If so, what tests/therapies have been done? _____

Did your mother take DES when she was pregnant? (please circle) Y N

Family Planning

Please check any method of contraceptive you have used in the past:

_____ Birth Control Pills _____Condoms _____ Depo-Provera/other injectable

_____ IUD (Intrauterine Device) _____Diaphragm _____ Withdrawal _____Spermicide

_____ Patch _____Vaginal Ring _____ Tubal Ligation _____ Vasectomy

_____ None _____ Other (Describe: _____)

Please check any method of Natural Family Planning you have used in the past:

_____None

_____ Symptothermal (please circle: CCL Northwest Family Services)

_____Ovulation Method (please circle: Billings FAF Creighton)

_____ Calendar/Rhythm

Which method do you currently use? _____

Reproductive History

How many times have you been pregnant? _____

Have you ever had a (please indicate year):

_____ Miscarriage _____ Abortion _____ Stillborn _____ Premature birth

Pregnancies:

Year	Weeks	Type of Delivery	Sex (M/F)	Birth Weight	Please describe any complications	Name

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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

Last Name _____, First Name _____