Desert Star
FAMILY PLANNING

PATIENT INFORMATION FORM

Patient's last name: _____ **First name:** _____ **Middle initial:** _____

DOB: _____ **Age:** _____ **Social Security #:** _____ Female ____ Male ____ Transgender ____

Address: _____ **Apt/Unit #:** _____

City: _____ **State:** _____ **Zip code:** _____ **Home phone #:** _____

Cell Phone #: _____ **Email Address:** _____

Preferred method of contact: (Please check all that apply) Home Phone _____ Cell Phone _____ Email _____

Relationship status: (Please check one) Never Married _____ Single _____ Married/Domestic Partner _____
Separated _____ Divorced _____ Widow _____ Other (Please list)_____

Race: (Please check all that apply) White _____ American Indian _____ Black or African American _____ Asian _____
Native Hawaiian or other Pacific Islander _____ Other _____ Decline to state _____

Ethnicity: (Please select only one) Hispanic/Latino _____ Non-Hispanic/Non-Latino _____ Declines to state _____

Occupation: _____ **Employer:** _____ **Phone number:** _____

How did you hear about us? (Circle one) Referred by Doctor Family/Friend Search engine Other

Emergency contact: _____ **Phone number:** _____ **Relationship:** _____

Were you referred by another facility? Name of Doctor/Facility: _____ **Phone #:** _____

INSURANCE INFORMATION

Primary Insurance: (If you have a secondary insurance, please provide the front desk both cards)

Person responsible for insurance: _____ Relationship to patient: _____

DOB: _____ Social Security #: _____ Phone #: _____

Name of Insurance: _____ ID/Policy #: _____ Group #: _____

Insurance Company's address: _____ City: _____

State: _____ Zip code: _____ Phone number#: _____

Most Insurance carriers require us to submit claims for patient services. For this reason, we request all patients to fill out completely and sign registration form on an annual basis to keep our records current. Thank you for your cooperation. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Physician. I understand that I am financially responsible for any balance. I also authorize Desert Star Family Planning or insurance company to release any information required to process my claims.

_____ _____

Patient Signature: **Date:**

_____ _____

Signature of Parent or Legal Guardian, if applicable: **Date:**

Office Use Only

Type of Identification/Number: _____ Staff initials: _____ Date: _____

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MEDICAL HISTORY

Print Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY Have you **EVER** had any of the following: (**Please complete BOTH columns.**)

Past/Now/Never		Past/Now/Never	
☐☐☐	**Anemia**	☐☐☐	**Stroke**
☐☐☐	**Anxiety**	☐☐☐	**Seizures or Epilepsy**
☐☐☐	**Bleeding Problems**	☐☐☐	**Bowel Disease** (e.g. IBS, Crohn's, Celiac)
☐☐☐	**Blood Transfusion**	☐☐☐	**Thyroid Disease**
☐☐☐	**Deep Vein Thrombosis**	☐☐☐	**Bladder Infection**
☐☐☐	**Pulmonary Embolism (PE) or Blood Clotting Disorders**	☐☐☐	**Sickle Cell Disease**
☐☐☐	**Long-term Steroid Medication Use** (e.g., prednisone)	☐☐☐	**Depression**
☐☐☐	**Genital Herpes** Last outbreak: _____/_____/_____	☐☐☐	**Uterine Abnormalities or Fibroids**

☐☐☐ **Cancer** – *If yes, what?* _____

☐☐☐ **Cardiovascular**: Irregular heartbeat, severe chest pain not resolved with antacids, heart disease, heart attack or serious heart valve problem

☐☐☐ **Chest/Breast**: Lump, constant pain, or nipple discharge – *If yes, describe:* _____

☐☐☐ **Chlamydia, Gonorrhea, Pelvic Inflammatory Disease (PID) or other sexually transmitted infection**

☐☐☐ **Elevated Blood Pressure**

☐☐☐ **Endocrine**: Excessive thirst or night sweats

☐☐☐ **Gastrointestinal**: Ongoing nausea or severe abdominal pain, change in bowel movements

☐☐☐ **Genitourinary**: Abnormal discharge – *If yes, describe:* _____

☐☐☐ **Genitourinary**: Itching or irritation of genital area

☐☐☐ **Genitourinary**: Pain or bleeding with sexual activity

☐☐☐ **Genitourinary**: Pain/burning or bleeding with urination

☐☐☐ **Genitourinary**: Severe pain with periods that may include nausea, vomiting, or interfere with school or work

☐☐☐ **Kidney Disease or Kidney Failure or Chronic Adrenal Failure**

☐☐☐ **Lymph**: Painful or swollen glands in your groin

☐☐☐ **Mouth**: Bumps or sores in the mouth – *If yes, describe*: _____

☐☐☐ **Neurological**: Migraine OR an increase or change in headaches

☐☐☐ **Psychosocial**: Difficulty sleeping, eating, going to work or school for greater than 3 weeks

☐☐☐ **Respiratory**: Difficulty breathing with exercise, Asthma, breathing problems, other lung disease (e.g., sleep apnea) / Inhaler use

☐☐☐ **Skin**: Rashes or lesions, bumps, sores – *If yes, describe*: _____

☐☐☐ **Other serious medical problems, illness, hospitalizations, surgeries, blood transfusions or exposure to blood products** *If yes, explain:* _____

☐☐☐ Any **CURRENT/ONGOING** medical problem being managed by another health care provider or any **PLANNED UPCOMING** major surgeries *If yes, explain:* _____

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Past/Now/Never

☐☐☐ **Any PAST Surgeries?** *If yes, what* and when: _____

☐☐☐ **Any Hospitalization(s)?** *If yes, when and for what and when:* _____
_____

SOCIAL HISTORY

Past/Now/Never

☐☐☐ **Do you smoke cigarettes / cigars or chew tobacco?** *If yes, how may/much do you smoke/chew a day?*_____

☐☐☐ **Do you drink alcohol?** *If yes, how often and how much:* _____

☐☐☐ **Have you ever used street or IV drugs or other substances**? _____
*If yes, please list types and last use dates:*_____

Do you feel **Safe** at Home? ☐ No ☐ Yes _____***WE CAN HELP!***

Do you have **concerns** regarding **Domestic Violence?** ☐ No ☐ Yes _____***WE CAN HELP!***

Do you have any allergies to medications, metals, latex, medications (including antibiotics/pain reducers), shellfish, or antiseptic solutions (iodine/alcohol/Hibiclens)?☐ No ☐ Yes

If yes, list allergy and reaction: _____

Are you currently taking any medications, drugs, over-the-counter or herbal medications, vitamins or mineral supplements? ☐ No ☐ Yes
If yes, please list: _____

FEMALE PATIENTS ONLY – Please complete the last three sections

MENSTRUAL HISTORY

When was the first day of your last normal menstrual period? ____/____/____
Age that you first started your period: _____
Was your last period normal? ☐ No ☐ Yes *If **no**, explain*: _____
Do you have problems with your period? ☐ No ☐ Yes *If **yes**, explain*: _____
Month/year of last pap smear: ____/____
Have you ever had an abnormal pap smear, colposcopy, cryotherapy, or LEEP? ☐ No ☐ Yes

CONTRACEPTIVE HISTORY

Are you interested in getting birth control today? ☐ No ☐ Yes *If **yes**, what:* _____
What birth control method are you currently using? _____
Any problems with this method? ☐ No ☐ Yes *If **yes**, explain:* _____
What methods have you used in the past? _____
Any problems with your previous methods? ☐ No ☐ Yes *If **yes**, explain*: _____

PREGNANCY HISTORY

Number of: **Pregnancies___ Vaginal deliveries___ C-sections___ Miscarriages___ Abortions___ Ectopic (tubal)___**

When did your last pregnancy end? ____/____/____ Any complications? _____
Are you breastfeeding now? ☐ No ☐ Yes

Patient Signature: _____ **Date:** _____/_____/_____

For Office Only

Staff Signature: _____ **Date:** _____/_____/_____