Women First
GYNECOLOGY & WELLNESS CLINIC

9600 BAPTIST HEALTH DR., SUITE 340
LITTLE ROCK, AR 72205
PHONE: (501) 248-0200 / FAX: (501) 248-0100

Date:_____/_____/_____

PATIENT INFORMATION

NEW PATIENT OF DR. OWENS: _____ OR PREEXISTING PATIENT OF DR. OWENS: _____

FIRST NAME:_____MIDDLE INITIAL:_____LAST NAME:_____

PREFERRED PRONOUNS:_____ LEGAL SEX: ___MALE ___FEMALE

SEX ASSIGNED AT BIRTH: ___Male ___Female ___Decline to Report HEIGHT: _____

PREFERRED LANGUAGE _____ DO YOU NEED AN INTERPRETER? ___YES__NO

DATE OF BIRTH:_____ AGE: _____ SOCIAL SECURITY #:_____

STREET ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____

PRIMARY PHONE:_____ HOME__MOBILE__WORK__SPOUSE__CAREGIVER__

SECOND PHONE:_____ HOME__MOBILE__WORK__SPOUSE__CAREGIVER__

E-MAIL ADDRESS:_____

EMPLOYER:_____POSITION:_____

EMERGENCY CONTACT:_____RELATIONSHIP:_____

EMERGENCY CONTACT PHONE:_____

PRIMARY CARE PROVIDER: _____

MARITAL STATUS:_____

PREFERRED METHOD OF CONTACT: ___MyChart ___Phone ___Email ___Text ___Mail

RACE (select all that apply): Asian / Black or African American / White or Caucasian / American Indian or Alaska Native / Native Hawaiian or other Pacific Islander / Other / Unknown / Decline to Report

ETHNICITY (select one): Non-Hispanic / Hispanic / Unknown / Decline to Report

FULL NAME:_____ DOB:_____ LAST MENSTRUAL PERIOD:_____

GENDER IDENTITY: Male / Female / Transgender Female / Transgender Male / Other / Decline to Report

SEXUAL ORIENTATION: Straight / Lesbian or Gay / Bisexual / Something else / Decline to Report

EMPLOYMENT: Full-time / Part-time / Unemployed / Retired / Student / Homemaker / Decline to Report

HIGHEST LEVEL OF EDUCATION: Not a high school graduate / GED / High School Graduate / Some College / Associates Degree / Bachelor's Degree / Master's Degree / Doctorate of Professional Degree / Decline to Report

INSURANCE INFORMATION

PRIMARY INSURANCE:

IS SUBSCRIBER THE SAME AS THE PATIENT? YES___NO___

FIRST NAME:_____MIDDLE INITIAL:_____LAST NAME:_____

DATE OF BIRTH:_____SOCIAL SECURITY NO.:_____

INSURANCE COMPANY:_____

INSURANCE ID #:_____SUBSCRIBER ID:_____

GROUP #:_____PATIENT RELATIONSHIP: SPOUSE___CHILD___OTHER____

SECONDARY INSURANCE FOR THE SAME PATIENT (IF APPLICABLE):

IS SUBSCRIBER THE SAME AS THE PATIENT? YES___NO___

INSURANCE COMPANY:_____

INSURANCE ID #:_____SUBSCRIBER ID:_____

GROUP #:_____PATIENT RELATIONSHIP: SPOUSE___CHILD___OTHER____

REASON(S) FOR TODAY'S VISIT (please circle)

Yearly Exam Birth Control Pelvic Pain Abnormal Bleeding/Cycles STD check

Vaginal Discharge Painful Sex Abnormal Pap Smear Bladder Issues Pelvic Organ Prolapse

Hot Flashes Night Sweats Sleep disturbance Brain Fog Joint Pain Muscle Pain

Decreased Sex Drive Vaginal Dryness Weight Gain Weight Loss Fatigue Hormone Replacement Therapy

___Other:_____

FULL NAME:_____ DOB:_____ LAST MENSTRUAL PERIOD:_____

MEDICAL HISTORY:

___High Blood Pressure ___HIV ___Stroke ___Blood Clot in Leg/Lungs

___Diabetes ___Breast Disease ___Gastrointestinal Problems ___Cancer ___Arthritis

___Heart Disease ___Constipation ___Anxiety ___Diarrhea ___Heart Disease

___Depression ___Asthma ___Blood in Stool ___Anemia ___Migraine

___Kidney Disease ___Alcohol Abuse ___Kidney Stones ___Thyroid Disease

___Drug Abuse ___Hemorrhoids ___Bleeding Disorders ___Liver Disease ___Substance Abuse

___Other:_____

GYNECOLOGY HISTORY AND HEALTH MAINTENANCE

Age of first menstrual cycle: ____ How many days do your periods last? ____

What is your period pattern? ___Regular ___Irregular

How heavy is your flow? ___Light ___Moderate ___Heavy

Heavy Period Symptoms? ___Cramping ___Bloating ___Nausea ___Diarrhea ___ Headaches

Any recent changes in periods?

Do you wear ___pads and/or___ tampons? How often do you change them?_____

Age at menopause (one full year without a period): _____Date of Last pap smear_____

Date of last Mammogram:_____Date of Last Colonoscopy_____

Have you ever had a abnormal pap smear? ___Yes ___No Date:_____

Have you ever had an abnormal mammogram? ___Yes ___No Date:_____

Have you ever had a cervical conization? ___Yes ___No Date:_____

Have you ever had a colposcopy? ___Yes ___No Date:_____

Have you ever had an endometrial biopsy? ___Yes ___No Date:_____

Have you ever had an endometrial ablation? ___Yes ___No Date:_____

Have you ever had a Bone Density Scan (DEXA)? ___Yes ___No Date:_____

FULL NAME:_____ DOB:_____ LAST MENSTRUAL PERIOD:_____

CURRENT MEDICATIONS

MEDICATION NAME	DOSE	FREQUENCY

Please Provide Your Pharmacy Name:_____Location:_____

List Drug Allergies:_____

If yes to Drug Allergies What was the Reaction: _____

SEXUAL HISTORY

Currently Sexually Active: ____ Yes ____No ____Not Currently ____Have Never Been

Have You Received the HPV Vaccine? ____ Date & Year: _____

Sexual Partners Are: ____Men ____Women ____Both

CHECK ANY THAT APPLY:

___NONE ___CHLAMYDIA ___ENDOMETRIOSIS ___PELVIC INFLAMMATORY DISEASE

___GONORRHEA ___SYPHILIS ___TRICHOMONAS ___HERPES-GENITAL

___OTHER:_____

Do you wish to have an STI Screening? ____Yes ____No

METHOD OF CONTRACEPTION:

___NOT NEEDED ___VASECTOMY ___RHYTHM METHOD ___NEXPLANON

___TUBAL LIGATION ___NONE ___CONDOMS ___NUVARING

___CONTRACEPTIVE GEL ___MIRENA IUD ___ESSURE ___PATCH

___BIRTH CONTROL PILL AND NAME: _____

___DEPO PROVERA ___PARAGUARD IUD OTHER: _____

FULL NAME:_____ DOB:_____ LAST MENSTRUAL PERIOD:_____

HOW LONG HAVE YOU USED YOUR CURRENT METHOD OF CONTRACEPTION? _____

OBSTETRICAL HISTORY

Never Been Pregnant: _____ Total Number of Pregnancies:_____

Please list all pregnancies and outcome below (**include deliveries, miscarriages, abortions and fetal deaths**)

Month/Yr	Gestational Age (Wks.)	Birth Weight	Male/Female	C-section /Vaginal Delivery	City / State	Complications

SOCIAL HISTORY

ARE YOU? ___SINGLE ___ENGAGED ___MARRIED ___SIGNIFICANT OTHER

___DIVORCED ___WIDOWED ___SAME SEX PARTNER

TOBACCO USE: ___NEVER ___CURRENT ___# OF CIGARETTES AND/OR ___VAPE

ALCOHOL USE: ___YES ___NO …IF YES, AVG # OF DRINKS PER WEEK____

DO YOU USE RECREATIONAL DRUGS? ___YES ___NO

IF YES, THE TYPE(S) USED:_____LAST USED:_____

HOW MANY TIMES PER WEEK? _____

DO YOU EXERCISE? ___YES ___NO …IF YES, HOW MANY TIMES PER WEEK _____

HOW LONG DO YOU DO YOU EXERCISE IN MINUTES EACH TIME: _____MINUTES

DO YOU EAT A HEALTHY DIET? ___DAILY ___SOME ___NO

Have you ever been abused? ___Yes ___No

If yes, please circle all that apply: ____Physical ____Emotional ____Sexual

Are you currently in a safe situation? ____Yes ____No

In the past 6 months, have you felt sad, empty or depressed? ____Yes ____No

Are you currently receiving treatment for anxiety or depression? ____Yes ____No

Do you have stable housing? ____Yes ____No

FULL NAME:_____ DOB:_____ LAST MENSTRUAL PERIOD:_____

Do you have transportation? ____Yes ____No

SURGICAL HISTORY

Hysterectomy: _____ Abdominal____Vaginal____Laparoscopic ____Robotic Year: _____

Removal of Ovaries: ____Yes ____No Year: _____

Tubal Ligation or Removal: ____Yes ____No Year: _____

D&C: ____Yes ____No Year: _____

Breast surgery: ____Yes ____No Year: _____

Any Other surgeries: ____Yes ____No Year: _____

Laparoscopy: ____Yes ____No Year: _____

If Yes to Laparoscopy, why was this procedure performed? _____

FAMILY HISTORY

MOTHER: ___LIVING ___DECEASED-CAUSE:
_____AGE_____

FATHER: ___LIVING ___DECEASED-CAUSE:
_____AGE_____

SIBLINGS: ___LIVING ___DECEASED-CAUSE:
_____AGE_____

CHILDREN: ___LIVING ___DECEASED-CAUSE:
_____AGE_____

ILLNESS	✓	WHICH RELATIVE(S)	AGE OF ONSET
DIABETES	☐		
STROKE	☐		
HEART DISEASE	☐		
BLOOD CLOTS IN LUNGS OR LEGS	☐		
HIGH BLOOD PRESSURE	☐		
HIGH CHOLESTEROL	☐		

FULL NAME:_____ DOB:_____ LAST MENSTRUAL PERIOD:_____

OSTEOPOROSIS (WEAK BONES)	☐		
BREAST CANCER	☐		
COLON CANCER	☐		
OVARIAN CANCER	☐		
BLEEDING DISORDER	☐		
ALZHEIMER'S DISEASE	☐		
OTHER:	☐		

I GIVE PERMISSION TO WOMEN FIRST CLINIC TO SPEAK WITH THE FOLLOWING INDIVIDUALS REGARDING MY MEDICAL RECORDS (Lab results, Insurance, Appointments):

NAME: _____RELATIONSHIP:_____PHONE:_____

NAME:_____RELATIONSHIP:_____PHONE:_____

I/WE CERTIFY THAT THE ABOVE FACTS ARE TRUE TO THE BEST OF MY KNOWLEDGE:

SIGNATURE X_____

I/WE AGREE TO ACCEPT TOTAL RESPONSIBILITY FOR ALL DAMAGES AND AGREE TO PAY AT THE TIME SERVICES ARE RENDERED. IN THE EVENT OF DEFAULT, I/WE AGREE TO PAY ALL COST OF THE COLLECTION, INCLUDING REASONABLE ATTORNEY FEES:

SIGNATURE X_____

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY FOR THE PREPARATION OF INSURANCE CLAIMS ON MYSELF AND AUTHORIZE THE INSURANCE TO MAKE PAYMENT DIRECT TO THE THIS CLINIC ON ANY UNPAID CLAIM.

SIGNATURE X_____