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

FIRST NAME:_____MIDDLE INITIAL:_____LAST NAME:_____

PREFERRED PRONOUNS:_____ LEGAL SEX: ___MALE ___FEMALE

SEX ASSIGNED AT BIRTH: ___MALE ___FEMALE ___DECLINE TO REPORT

PREFERRED LANGUAGE _____ DO YOU NEED AN INTERPRETER? ___YES__NO

DATE OF BIRTH:_____SOCIAL SECURITY #:_____

STREET ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____

PRIMARY PHONE:_____ HOME__MOBILE__WORK__SPOUSE__CAREGIVER__

SECOND PHONE:_____ HOME__MOBILE__WORK__SPOUSE__CAREGIVER__

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

- Hormone Therapy Replacement: Select All That Apply

Decline in general well being, Joint Pain, Muscle Pain, Excessive Sweating, Sleep Problems, Increase need for Sleep, Physical exhaustion/lacking vitality, Decrease in muscular strength, Feeling you has passed your peak, Feeling Burnt Out, Decrease in Beard Growth, Decrease in ability/frequency to perform sexually, Decrease in the number of morning erections, Decrease in Sexual Desire/Libido, Irritability, Depressive Mood, Anxiety

CURRENT MEDICATIONS

MEDICATION NAME	DOSE	FREQUENCY

Please Provide Your Pharmacy

Name:_____Location:_____

List Drug Allergies:_____

If yes to Drug Allergies What was the Reaction:

_____

MEDICAL HISTORY:

___High Blood Pressure ___HIV ___Stroke ___Blood Clot in Leg/Lungs ___ HSV Type I/II

___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:_____

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

METHOD OF CONTRACEPTION:

___ Condoms ____ Vasectomy

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:_____

SURGICAL HISTORY

Type of Surgery	Date

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	☐		
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:

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:

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_____