BAPTIST HEALTH WOMEN'S CLINIC- CONWAY

Name: ___________________________ **DOB**: ____________ **SS#** _________________ **Sex:** Male/Female

Gender Identity: _________________________ **Preferred Pronouns:** ______________________________

Race: White
Black
Hispanic
Other: ___________

Ethnicity: Hispanic
Non-Hispanic

Primary Language: English
Spanish
Other: ____________

Marital Status: Single
Married
Divorced
Separated

Religion: ___________________

Address: ___________________________**City:**___________________ **State:** ____ **Zip code:** _________

Primary Phone: ____________________________ **Other:** _______________________ **Home/Cell**

Email: ___________________________________ **Primary Care Provider:** __________________________

Emergency Contact: _____________________ **Relationship:** ____________ **Phone:** ________________

Employment: Full-time Part-time Unemployed Student **Job Title:** ______________________
Work location: ________________________ **Work phone:** _______________________

Guarantor Information (Person Responsible for Bill)

Name: ___________________________ **DOB:** _____________________ **Sex: Female/Male**

SS# ______________________ **Phone:** _________________________ **Relationship:** __________________

Work Location: ___________________________________ **Full-time/ Part-time**

Insurance Information

(Please attach your insurance card to scan into the system)

Primary Insurance Carrier______________________________ **Member ID** ________________________

Subscriber: _______________________ **Subscriber DOB:** ________________

Secondary Insurance Carrier ____________________________ **Member ID** _________________________

Subscriber: _______________________ **Subscriber DOB:** _____________________________________

I give permission to BHWC to speak with the following individuals regarding my medical records (Lab results, insurance, appointments) if I am not available.

Name: ____ **Phone:** ______________________

Name: ____ **Phone:** ______________________

Name: ____ **Phone:** _______________________

I certify that all of the above information is correct for billing purposes and it is my responsibility to notify BHWC of any changes to my information.

Patient Signature: _________________________________ **Date:** _________________________________

BAPTIST HEALTH WOMEN'S CLINIC- CONWAY

Name: _______________________________DOB: _______________ Last Menstrual Period: _________

Reason for Today's Visit (please circle)

Yearly Exam Birth Control Pelvic Pain Abnormal Bleeding/Cycles STD Check
Pregnancy Vaginal Discharge Painful Sex Abnormal Pap smear Ovarian Cyst
Infertility Bladder Issues **Other: _____________________________**

Current Allergies: ____

Current Medications: ____

____

Current Pharmacy: ____ City: _________________________

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 Del	City/State	Complications

Gynecology History:

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

Period Symptoms: (Circle all that apply) Cramping Throbbing Nausea Headaches Diarrhea Bloating

Age of Menopause (if applicable): __________

Date of Last Pap smear: ___________________ **Date of Last Mammogram**: ____________________

Have you ever had an abnormal Pap smear? Yes No Date: ______________

Have you ever had an abnormal Mammogram? Yes No Date: ______________

Sexual History:

Age of onset of sexual activity: __________ Currently sexual active: Yes No

Partners: Male Female Both # of Current Partners: ______ # of Lifetime Partners: ______

Do you use contraception: Yes No Type of contraception? __________________________________

Have you ever had an STD? Yes No If so, what STDs have you had? __________________

Did you receive the HPV Vaccine? Yes No Unsure

BAPTIST HEALTH WOMEN'S CLINIC- CONWAY

Name: ____**DOB:** _____________________

Medical History: (circle all that apply)

Diabetes	High Blood Pressure	Heart Attack	Stroke
Asthma	Seizures	Breast Disease	Anxiety
Depression	Cancer	Thyroid Problems	Ovarian Cysts
Substance Abuse	Herpes	HIV	Hepatitis
Sickle Cell	Blood Clot in leg/lungs	Migraines	Bleeding Disorder

Other: ____

Surgical History: (circle all that apply and include date if known)

Hysterectomy ___________	Tubal Ligation________	Laparoscopy_________
Ovaries Removed __________	D&C _________	C-Section___________
Appendix Removal_____________	Gallbladder Removal ________	Breast Surgery_________

Any other surgeries: ____

Family History: (circle for Immediate Family Members only)

Diabetes	Depression	Osteoporosis	Heart Disease	Stroke
Substance Abuse	High Cholesterol	Infertility	Cancer (type): _______________	
Bleeding Disorder	Blood Clot in legs or lungs			

Other: ____

Social History:

Do you drink Alcohol?	Yes	No	Amount: _____________________________
Do you use drugs?	Yes	No	Type: _________________ Amount: _______________
Do you use Tobacco?	Yes	No	Vapor Cigarettes Smokeless Tobacco
			Amount: ______________ Years Used: _____________

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 depression or anxiety? Yes No

Have you ever seen a therapist/counselor/psychiatrist? Yes No

BAPTIST HEALTH WOMEN'S CLINIC- CONWAY

Name: ____ **DOB:** ______________________

Today's Date: _______________________________

Review of Systems: *Please circle all that apply*

General: Fever, Chills, Fatigue, Weight Loss, Weight Gain

ENT: Sore Throat, Hearing Loss, Vision Loss, Chronic Cough

Cardio: Chest Pain, Palpitations, Swelling Legs

Respiratory: Cough, Shortness of Breath, Wheezing

Endocrine: Unexpected Weight Changes, Excessive Thirst, Hot Spells

Heme-lymph: Bleeding, Bruising, History of Transfusions

Neuro: Confusion, Memory Loss, Numbness, Tingling

Musculoskeletal: Back Pain, Joint Stiffness, Mobility Issues

Emotional: Depression, Anxiety, Other: ____

BAPTIST HEALTH WOMEN'S CLINIC- CONWAY

Name: ____**DOB:** ________________________

********* If you are pregnant, please continue********

Genetic Screenings	Yes	No
Thalassemia		
Cystic Fibrosis		
Congenital Heart Defects		
Huntington's Chorea		
Down Syndrome		
Tay-Sachs		
Fragile X		
Hemophilia		
Muscular Dystrophy		
Sickle Cell Trait or disease		
Neural tube defects (spina bifida, anencephaly, meningomyelocele)		
Other birth defect or chromosomal disorder not listed		

History of congenital disorders (birth defects) ____

Do you have a history of any of the following during pregnancy?

Preterm Labor/Delivery	Yes	No
Pre-Eclampsia/Eclampsia	Yes	No
Gestational Hypertension	Yes	No
Gestational Diabetes	Yes	No
Neonate with GBS Sepsis	Yes	No
Postpartum Hemorrhage	Yes	No
Shoulder Dystocia	Yes	No
Forceps or Vacuum Delivery	Yes	No

Do you plan to Breastfeed after delivery?	Yes	No	Not Sure
Do you plan on permanent sterilization after this pregnancy?	Yes	No	Not Sure

If no, what do you plan to use to prevent pregnancy after delivery? _________________

I certify that all of the above information is correct.

Patient Signature: ____ **Date:** ______________________