

Medical Abortion History

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

On what date did your last period start? \_\_\_\_\_ Was it a normal period? yes, If no, explain \_\_\_\_\_

Do you have any allergies (including allergies to latex, iodine, anesthesia and medications)? \_\_\_\_\_ If yes, please list \_\_\_\_\_

Have you ever been a patient in a hospital or had a major illness? yes no

If yes, explain \_\_\_\_\_

List all current medical problems \_\_\_\_\_

Do you think you might have a sexually transmitted infection? \_\_\_\_\_

What medications do you take? \_\_\_\_\_

Do you have asthma? yes no If yes, do you have an inhaler? yes no If yes, Do you have it with you today? \_\_\_\_\_

Do you smoke? yes no If yes, how much? \_\_\_\_\_

Do you now have or have you ever had?

Yes No

- High Blood Pressure
- Heart Disease/Heart Murmur
- Heart Attack or Severe Chest Pains
- Stroke
- Blood Clots
- Migraine Headaches
- Other severe headaches
- Seizures

Yes No

- Anemia
- Asthma
- Tuberculosis
- Cancer
- Diabetes
- Abnormal Pap Smear
- Fainting/vaso vagal reaction
- Severe depression

Yes No

- Thyroid disease
- Hepatitis, or liver disease
- Mononucleosis in the past year
- Pelvic Inflammatory Disease
- High cholesterol or high lipids
- Breast lump(s)
- Adrenal failure
- Clotting disorder/von Willebrand's

Obstetric History If you have never been pregnant before, skip this section

How many times have you been pregnant? \_\_\_\_\_ Have you been pregnant in the last year? Yes No

Are you breast feeding now? Yes No

How many times have you given birth? \_\_\_\_\_ How many living children do you have? \_\_\_\_\_

How many: Premature births \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_ Stillbirths \_\_\_\_\_ Ectopic (in tubes) \_\_\_\_\_

During your previous pregnancy(s) did you have any complications like:

- High Blood Pressure Diabetes other \_\_\_\_\_ No complications

What do you want to do to prevent pregnancy in the future? \_\_\_\_\_

You will have an ultrasound today. Would you like to look at your ultrasound photograph? Yes No

The ultrasound may reveal a multiple pregnancy (more than one embryo).

If this occurs: (please ✓)  Tell me  Please do not tell me  I'd like to discuss this beforehand

Is there anything else we should know about you? \_\_\_\_\_

Signature of client \_\_\_\_\_

STAFF USE ONLY

Counseling Notes:

Describe emotional support system : \_\_\_\_\_

If <18 yrs, is there parental involvement: Y N If No, describe situation/other trusted adult: \_\_\_\_\_

Client is here today with \_\_\_\_\_

Other: \_\_\_\_\_

Signature of COA \_\_\_\_\_

Signature of Clinician \_\_\_\_\_