MEDICAL HISTORY

Time: Appointment _____ Arrival_____

Patient Name_____
Prefer Nickname?_____ Birth date_____ Age ___

Address:_____City:_____

State:_____Zip:_____County_____
If we must contact you by mail, are a blank envelope and code name necessary? ☐ Yes, code is "Toni" ☐ No

Phone (H): _____"**Toni" code? ☐ Yes ☐ No**

Phone (W):_____**"Toni" code? ☐ Yes ☐ No**

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Domestic Partner

Name of person with you today: _____

Transportation home: ☐ Car ☐ Cab ☐ Bus ☐ Train ☐ Walk ☐ By self ☐ With family/friend ☐ Other_____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship:_____

Phone: _____

Address: _____

City:_____ State: ____ Zip:_____
Does she/he know you are having an abortion today? ☐Yes ☐ No

FAMILY HISTORY

YES	NO	Have your parents, brothers or sisters had any of the following?
		1. I am adopted, birth family history is unknown
		2. Breast Disease
		3. Birth Defects or Genetic Problems
		4. Cancer
		5. Diabetes
		6. Heart Attack
		7. High Blood Fats (cholesterol)
		8. High Blood Pressure
		9. Strokes or Blood Clots
		10. Problems with Anesthesia

YOUR MEDICAL HISTORY

YES	NO	YOUR MEDICAL HISTORY
		11. Allergies to any drug, medication, latex, or other substance including iodine, local anesthesia, muscle relaxants, barbiturates (list)
		12. Anemia or Sickle Cell Anemia
		13. Asthma (last attack, triggers)
		14. Bleeding Tendency or Blood Clotting Disorder
		15. Blood Transfusion
		16. Brain Injury
		17. Breast Problems / Surgery
		18. Breastfeeding
		19. Breathing Problems
		20. Birth Defects or Genetic Conditions
		21. Blood Clots (head / legs / lungs)
		22. Cancer (Where, when)
		23. Chest Pains / Shortness of Breath
		24. Chronic cough / Bronchitis
		25. Complications during or after Anesthesia
		26. Counseling / Therapy
		27. Depression / Anxiety / Psychiatric History
		28. Diabetes (controlled?)
		29. Disease or Surgery of uterus/tubes/ovaries
		30. Dizziness / Fainting / Blurred Vision
		31. Ectopic Pregnancy
		32. Frequent Headaches
		33. Glaucoma
		34. Heart Disease / Murmur / Mitral Valve Prolapse
		35. HIV (AIDS)
		36. High Blood Pressure (controlled?)

YOUR MEDICAL HISTORY (CONTINUED)

YES	NO	YOUR MEDICAL HISTORY (CONTINUED)
		37. High Cholesterol / Triglycerides
		38. Hospitalization (year, reason)
		39. Kidney Disease / Chronic Adrenal Failure
		40. Liver Disease (active?) / Hepatitis / Jaundice
		41. Medication Currently Taking (name, dose)
		42. Medication Taken Today (name, amount, time)
		43. Migraine Headaches
		43. Numbness / Sensory Loss
		44. Pap smear with Abnormalities (when, treatment)
		45. Pap Smear within last year
		46. Pelvic Infection / Pain / Pelvic Inflammatory Disease
		47. Recent Cold Symptoms
		48. Rheumatic Fever
		49. Seizures (date of last, meds) / Epilepsy
		50. Sexually transmitted infection Check type: ❑chlamydia ❑gonorrhea ❑PID ❑HPV ❑genital warts ❑herpes ❑syphilis
		51. Sleep Apnea
		52. Stroke
		53. Swollen Feet or Ankles
		54. Thyroid Disease ❑ hyper ❑ hypo
		55. TB (Tuberculosis)
		56. Upper Respiratory Infection / Pneumonia
		57. Urinary tract or Bladder Infection
		58. Uterine Fibroids / Abnormalities
		59. Vaginal Infection
		60. Varicose Veins

STAFF COMMENTS / EXPLANATIONS (by number)

Patient Name _____

Chart # _____ **Date**_____

PREGNANCY HISTORY: Not counting this pregnancy, please list the years of previous pregnancies and mark the outcomes.								
Delivered							**Not delivered**	
Year	*Live/Stillbirth*	*c-section/vaginal*	*multiple*	*living*	*Placed for adoption*		*Year*	*Abortion/Miscarriage/Ectopic*
	☐ / ☐	☐ / ☐	☐	☐	☐			☐ / ☐ / ☐
	☐ / ☐	☐ / ☐	☐	☐	☐			☐ / ☐ / ☐
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	☐ / ☐	☐ / ☐	☐	☐	☐			☐ / ☐ / ☐
Staff total	/	/						/ /

MENSTRUAL HISTORY
First day of your last period:
It seemed: ☐ normal ☐ not normal
Number of pads / tampons used on heaviest day:
Flow is: ☐ light ☐ moderate ☐ heavy
Bleeding lasts _____ days.
Periods: ☐come every _____ days. ☐are irregular.
Periods are painful: ☐ Yes ☐ No
CONTRACEPTIVE HISTORY
Birth control used at time of pregnancy:
How long did you use this method?
What method do you want to use now?
Emergency Contraception
Do you know of Emergency Contraception (PLAN B)?
Would you like to purchase PLAN B today?

CONTRACEPTIVE HISTORY CONTINUED	
Which of the following methods have you used in the past?	
Method	**Comments/Problems**
☐ Tubal ☐Vasectomy	
☐ IUD, is it still in place?	
☐ Norplant	
☐ Implanon	
☐ Depo provera injection	
☐ Nuvaring	
☐ Ortho Evra Patch	
☐ Birth control Pills	
☐ Condoms	
☐ Diaphragm / Cervical cap	
☐ Foams / Spermicides	
☐ Rhythm, Natural Family Planning	
☐ Other	
☐ None	

SOCIAL HISTORY		
YES	**NO**	
		1. Smoke: #_____cigarettes / day
		2. Currently use alcohol / drugs (last use)
		3. History of addiction (drug of choice)
YES	**NO**	**Have you recently experienced:**
		4. Emotional problems
		5. Relationship problems
		6. Death of a family member or friend
		7. Job Loss or Financial problems
		8. Housing or School problems
		9. Legal problems (specify)
		10. Fear of your partner / family member
		11. Someone forced you to have sex?
		12. Someone hits, slaps, kicks, hurts you?
		13. Have you ever been abused sexually?

STAFF COMMENTS / EXPLANATIONS (by number where indicated)

To the best of my knowledge the information I have provided is correct and complete.

Patient Signature: _____ **Staff Signature/Title:** _____