Dear Patient,

In order for Planned Parenthood/Women's Health Services of Western PA to comply with the reporting requirements of the Pennsylvania Abortion Act, it is necessary to obtain the following information about you.

Please be assured that all the information is confidential and the reports do not include your name.

<table>
<tr><td>Patient I.D. #
(DO NOT USE NAME)
________________________________</td><td></td></tr>
<tr><td>1. AGE LAST BIRTHDAY

____
YEARS</td><td>PATIENT'S RESIDENCE
The state and county should be where you are currently living

2a. STATE ____________________________

2b. COUNTY __________________________</td></tr>
<tr><td>3. OF HISPANIC ORIGIN
(Specify No or Yes. If yes, please specify Cuban, Mexican, Puerto Rican, etc.)

SPECIFY: ________________________

Hispanic refers to people whose origins are from Spain, Cuba, Puerto Rico or the Spanish speaking countries of Central of South America.
This question is not part of the race item.
Hispanic is an ethnic group, not a race.
Hispanic origin may be of any race.</td><td>4. RACE – White, Black, American Indian, etc.

For Asian or Pacific Islanders, enter your nations origin, such as Chinese, Korean, Japanese, Filipino or Hawaiian.

If you are more that one race enter both.

________________________________</td></tr>
<tr><td>5. MARRIED
Check yes if you are legally married, including separated at the present time.

YES ________ NO_________

7. MEDICAL ASSISTANCE

Check Yes if you have Medical Assistance Coverage.
Yes______________ No_____________</td><td>6. EDUCATION
(Specify only the highest grade completed)

Do not include beauty, barber, trade, business, technical or other special schools.

ELEMENTARY/SECONDARY (0-12)
____

COLLEGE (1-4 or 5+)
________________________________</td></tr>
</table>