

WOMAN'S HEALTH OPTIONS

IDENTIFICATION FORM/ FOR PROCEDURE

Date: _____

Time: _____

Last Name: _____

First Name: _____

Address: _____
(Street/Mailing Address)

(City/Town) (Province/Country) (Postal Code)

Date of Birth: _____ Age: _____
Day Month Year

Telephone No.: (_____) _____ (_____) _____
(Home) (Business)

Telephone Number (other) _____

E-Mail Address _____

Occupation: _____ Marital Status: _____

Country of Birth: _____

What is your first language? _____

Emergency Contact: _____
(Name) (Phone Number)

FOR OFFICE USE ONLY

File No: _____ Date: _____

Fee: _____ U/S Fee: _____ Receipt No. US _____

Paid: _____ Receipt No. _____

Balance: _____ Depo Evra Nuvaring IUD Visa Cash MC Amex Debit

Province: AB BC SK ONT NT NU YK RCMP D.N.D. Immigration Cash Visa MC Amex Debit

FAC 87.29A 87.0A BM X236 X239 X258 (79.29E-622.8) 13.99BA/622.1

03.03A/V26.4 03.04A/V25.9 81.8/V25.1

Date appointment booked: _____

MEDICAL HISTORY

1. Circle present symptoms of pregnancy: frequent urination / enlarged breasts / nausea / vomiting / heartburn
2. Did you use Plan B (Morning after pill) to try and prevent this pregnancy? Y N
3. If it were discovered that you were pregnant with twins would you want to know? Y N
4. How many previous pregnancies have you had? _____.
5. How many children do you have? _____. What are their ages? _____
Are you presently breastfeeding? Y N
Did you have any problems with previous pregnancies? Y N If yes, what were they: _____

6. How many vaginal deliveries have you had? _____
7. Have you had any previous cesarean sections? Y N
If yes, why _____
8. Have you ever had a miscarriage? Y N
If yes, how many _____
9. Have you ever had an ectopic pregnancy (tubal pregnancy)? _____
10. Have you ever had an abortion before? Y N If yes, where and when _____
11. Have you ever had a pap smear / pelvic exam before? Y N
If yes, when was your last pap smear? _____
Have you ever had an abnormal pap smear? Y N
Have you ever had pelvic inflammatory disease or endometriosis? Y N
Have you ever had an STI (sexually transmitted infection)? Y N If yes, was it treated? Y N
Would you like us to test for bacterial vaginosis, gonorrhea, chlamydia and a pap smear? Y N
If yes, provide a phone number or email address where you can be contacted. _____
You will only be contacted if results are positive.
12. Have you ever had surgery on your Uterus, Fallopian Tubes or Cervix? Y N
If yes, what type of surgery?

13. Have you ever been admitted to a hospital before? Y N If yes, what for: _____

14. Have you ever had or do you have any of the following (please circle)?
None - Epilepsy – Diabetes – High Blood Pressure - Panic Attacks - Asthma/Hay Fever
Bleeding Problems - Anemia - Hepatitis – Thyroid - HIV - AIDS - Inflammatory Disease
Ulcers and Heart Burn Rapid / Irregular / Heart Rate - Crohn's - Ulcerative Colitis
Depression - Liver - Renal - von Willebrand disease – Hyper emesis – Immune Thrombocytopenic Purpura
Other _____

15. Do you have any allergies that you are aware of? Y N If yes, see below.

Allergy		REACTION		ALLERGY		REACTION	
Penicillin	Y N			Sulfa	Y N		
Tetracycline	Y N			Flagyl	Y N		
Nesacaine	Y N			Gentamicin	Y N		
Xylocaine	Y N			Cipro	Y N		
Lidocaine	Y N			Erythromycin	Y N		
Demerol	Y N			Advil	Y N		
Codeine	Y N			Amoxicillin	Y N		
Morphine	Y N			Ampicillin	Y N		
Tylenol	Y N			Anaprox	Y N		
Latex	Y N			Cytotec	Y N		
Methotrexate	Y N			Remifentanil	Y N		
Fentanyl	Y N			Versed	Y N		
Other							

16. Do you have any environmental or food allergies? Y N Unknown If yes, please list below

17. Are you allergic to anesthesia? Y N Unknown

18. Do you, or anyone in your family, have malignant hyperthermia (severe over heating of the body generally due to anesthetic)? Y N Un known

19. Have you, or any close relative, had a venous thrombosis (blood clot in leg, thigh, lung or pelvis)? Y N Unknown

20. Please list ANY medications, remedies you take on a daily/regular basis: _____

21. Do you smoke? Y N

22. Do you use recreational drugs on a regular basis or have you been heavily dependent in the past? Y N
 If yes, please circle: Speed, Cocaine, Crack, Marijuana, Ecstasy, Mescaline, Crystal Meth, LSD,
 Methadone, Heroin, Morphine, Alcohol, other.
 Have you used any in the last 24 hours? Y N If yes, what _____ how much _____

23. What method of birth control were you using when you became pregnant?

24. What method of birth control would you like to use in the future? _____
 Birth control requested _____ Rx Sample / Quick start

25. You need to see a doctor in 2 weeks for a check up.
 Do you have a doctor you can see for this purpose? Y N
 If no, referred to _____

1. Whose decision is it for you to have this abortion? _____

2. What would be helpful for you today?

___ Having the procedure explained to me.

___ Getting birth control information.

___ Being able to talk about my feelings with someone.

___ Having my support person with me during the abortion.

___ Does your support person want to speak with a counselor.

___ Getting more information about fetal development.

___ Having something to remember the pregnancy by.

___ Talking about spiritual concerns and /or getting ideas about rituals or ceremonies.

___ Referral for counseling.

___ Do you want a counselor to phone you to follow up on your appointment.

___ Viewing the fetal tissue and remains after the procedure.

___ Taking the fetal tissue and remains after the abortion.

___ I don't want to know about anything today.

3. Have you ever been hit, slapped, choked, kicked, physically hurt or threatened by a current or former partner? Y N

4. Has anyone ever made you take part in sexual activity when you did not want to? Y N

5. Do you have any other concerns today? _____

I last ate at: _____ I last drank at: _____

I HEREBY DECLARE THAT I FILLED OUT THIS FORM TO THE BEST OF MY ABILITY

Date: _____

Signature: _____