

Number \_\_\_\_\_

### PERSONAL & MEDICAL HISTORY

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

ASSURANCE OF CONFIDENTIALITY: This medical record is confidential and will not be released to anyone without your written consent, except as may be required by law.

Name \_\_\_\_\_ Age \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

1. When was the first day of your last menstrual period? \_\_\_\_\_
2. Are your periods normal?  Yes  No How many weeks pregnant do you think you are today? \_\_\_\_\_
3. How many times have you been pregnant? \_\_\_\_\_  
 Number of children: Living \_\_\_\_\_ Dead \_\_\_\_\_ Miscarriages \_\_\_\_\_  
 Did you have complications with your pregnancy or delivery?  Yes  No  
 Explain \_\_\_\_\_
4. Birth date of youngest child: \_\_\_\_\_ Are you breast feeding?  Yes  No
5. Number of abortions \_\_\_\_\_ Date of last abortion \_\_\_\_\_ Did you have complications?  Yes  No
6. Who accompanied you to the clinic? \_\_\_\_\_ Relationship \_\_\_\_\_
7. The name of the person who will be driving you home: \_\_\_\_\_
8. Who to contact in case of an emergency.  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

1. Have you ever had any serious illness or surgery in the past? If yes explain: \_\_\_\_\_
2. Are you allergic to any medication? What kind? \_\_\_\_\_
- 2a. Are you allergic to latex?  Yes  No If yes, please explain: \_\_\_\_\_
3. Are you taking any medicine now? What kind? \_\_\_\_\_
4. Are you taking blood thinners or corticosteroids? If yes explain: \_\_\_\_\_
5. Have you taken any medicine during this pregnancy? If yes explain: \_\_\_\_\_
6. Have you ever been counseled by a psychiatrist/psychologist/Social Worker? If yes explain: \_\_\_\_\_
7. Do you smoke?  Yes  No How many cigarettes or packs / day? \_\_\_\_\_
8. Have you ever been told by a doctor not to take the birth control pill? \_\_\_\_\_
9. Have you ever had (check if yes):

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Alcohol or Drug Addiction   | <input type="checkbox"/> Cancer (Breast or other) | <input type="checkbox"/> Mitral Valve Prolapse        |
| <input type="checkbox"/> Anemia or Blood disease     | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Pelvic Infection P.I.D.      |
| <input type="checkbox"/> Asthma, Respiratory Disease | <input type="checkbox"/> H.I.V.                   | <input type="checkbox"/> Rheumatic Fever              |
| <input type="checkbox"/> Blood Transfusions          | <input type="checkbox"/> Fibroids                 | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Blood Clotting Disorder     | <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> Eating Disorder              |
| <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Seizures                 | <input type="checkbox"/> Migraines                    |
| <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Kidney, Liver Disease    | <input type="checkbox"/> T.B.                         |

If yes to any of the above explain: \_\_\_\_\_

10. Have you ever had a reaction to Lidocaine, Novacaine, Carbocaine or similar anesthetic?:  Yes  No  
If yes explain: \_\_\_\_\_
11. Are you allergic to mifepristone, misoprostol or other prostaglandin? If yes explain: \_\_\_\_\_
12. Do you currently have a doctor?  Yes  No

DOCTOR'S NAME \_\_\_\_\_ CITY \_\_\_\_\_

MENSTRUAL & OB HISTORY

MEDICAL HISTORY