Label

YES	NO	GENERAL HEALTH INFORMATION
		My health is generally good
		Tobacco use? Number of years___ how many a day___
		Alcohol use? How many drinks per week? ______
		Do you use any drugs recreationally? If so please describe type and frequency of use ______________________________ ______________________________
		Do you use any drugs intravenously currently or in the past (IV)? **Y N**
		Any history of cancer? If yes where/ when? ______________________________
		Are you being treated for any illness/condition now? If yes, what? ______________________________
		Do you currently take medication? (Prescription, Over the Counter or Herbal) If yes, please list: ______________________________
		Any Allergies to the following? Penicillin **Y N** Cytotec **Y N** Doxycycline **Y N** Latex **Y N** Lidocaine **Y N** Epinephrine **Y N** Codeine **Y N** Flagyl/ Metronidazole **Y N** Iodine **Y N** Iburprofen **Y N** Shellfish **Y N** Tylenol **Y N** Methergine **Y N** Aspirin **Y N**
		Do you have any known **drug allergies**? If so, please list and describe reaction to medication. ______________________________ ______________________________
YES	**NO**	**CARDIORESPIRATORY**
		Mitral Valve Prolapse
		Heart Murmur
		Heart Attack
		Blood clots (lung/head/legs)
		Stroke
		High Blood Pressure
		Asthma or other breathing problems
		Tuberculosis
YES	**NO**	**GASTROINTESTINAL**
		Stomach or Bowel problems?
		Liver problems?
		GENITOURINARY
		Bladder or kidney problems
		Uterine fibroids
		Ovarian Cysts
		Vaginal Discharge? If so please describe ______________________________
		Endometriosis
YES	**NO**	**RHEUMATOLOGICAL**
		Lupus
		Rheumatoid Arthritis

YES	NO	**NEUROLOGICAL**
		Migraine headaches
		Seizures/ Epilepsy
YES	**NO**	**PSYCHOLOGICAL**
		Depression/ Anxiety
		Biploar Disorder
		Schizophrenia
YES	**NO**	**ENDROCINE**
		Thyroid Problems Hypo/Hyper
		Diabetes
YES	**NO**	**HEMATOLOGICAL**
		Anemia
		Sickle cell Disease/ Trait
		Bleeding Disorder
		Hospitalization and Surgeries
Year	**Reason**	
Year	**Reason**	
		Accidents and Injuries
Year	**Reason**	
Year	**Reason**	
YES	**NO**	**MENSTRUAL HISTORY**
		Abnormal Pap Test
		Previous Leep, Cone Biopsy or Cryosurgery? If yes, when?________________________
		History of sexually transmitted infection? When? ______________Treated Y or N Circle type: Herpes Chlamydia Gonorrhea Syphilis Genital Warts Hepatitis PID HIV
		Regular Periods?
		Last period started: ___/_____/_____
		Spotting between periods?
		CONTRACEPTIVE HISTORY
		Method of birth control used at conception?_________________________
		Length of use?____
		Any Problems with this method?________________________________
		What method do you want to use now?_____________________________
YES	**NO**	**SOCIAL HISTORY**
		Are you currently living in a secure and supportive environment?
		Do you need any information or assistance regarding any type of abuse?
		Has anyone forced you to have sex?
		Are you afraid of your partner?

Any medical conditions not listed above: ____

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

____ _________________________

Patient Signature Date

Counseling notes: The above patient is secure with her decision to terminate this pregnancy. She has reviewed all of her options. The procedure & aftercare instructions were discussed. The patient understands possible risks& complications. All of her questions were answered. Patient verbalized understanding of all information.

Counselor Signature____ Date_________________