Label

| YES | NO | GENERAL HEALTH INFORMATION |
|---|---|---|
| | | My health is generally good |
| | | Tobacco use? Number of years how many a day |
| | | Vape use? Number of years how many times a day |
| | | Alcohol use? How many drinks per week? |
| | | Do you use any drugs recreationally? If so, please describe type and frequency of use<br>_____<br>_____ |
| | | Do you use any drugs intravenously (IV) currently or in the past? |
| | | Any history of cancer? If yes where/ when?<br>_____ |
| | | Are you being treated for any illness/condition now?<br>If yes, what? _____ |
| | | Do you currently take medication? (Prescription, Over the Counter or Herbal) If yes, please list:<br>_____ |
| | | **Any Allergies to the following?**<br>Penicillin Y N Cytotec Y N<br>Doxycycline Y N Latex Y N<br>Lidocaine Y N Epinephrine Y N<br>Codeine Y N Flagyl/ Metronidazole Y N<br>Ibuprofen Y N Methergine Y N<br>Tylenol Y N Aspirin Y N<br>Betadine 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**<br>Circle type: Herpes Chlamydia Gonorrhea Syphilis<br>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. I have received my aftercare instructions.

_____ _____

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_____