

MEDICAL HISTORY – ABORTION CARE SERVICES

Legal name _____ Chosen Name _____ Pronouns (ex: he/she/they/ze) _____

Self-declared gender F M Non-binary Other _____ Sex assigned at birth F M Other _____

Gender designation on medical insurance records? F M Self-identified race or ethnicity: _____

MEDICAL HISTORY

General Medical History (current or past)

- Alcohol or substance use disorder
- Anemia / low iron
- Asthma
- Autoimmune disorder: _____
- Bleeding disorder
- Blood clotting disorder
- Blood transfusion
- Cancer: _____
- Depression and/or anxiety
- Diabetes
- Epilepsy / seizures
- Heart disease
- Hepatitis/liver disease
- High blood pressure (chronic)
- Hypothyroid / hyperthyroid
- Kidney disease
- Lung disease
- Migraine headaches
- Sickle cell disease
- Stroke
- Suicidal thoughts/attempts
- Weight loss medications
- Weight loss surgery

Reproductive Health History (current or past)

- Abnormal pap smear
- Abnormal uterus shape
- Breast/chest cancer
- Cervical biopsy / LEEP procedure
- Chlamydia infection
- Endometriosis
- Endometritis (uterine infection)
- Fibroids
- Gonorrhea infection
- Ovarian cancer
- Pelvic inflammatory disease (PID)
- Polycystic ovarian syndrome
- Postpartum hemorrhage
- Preeclampsia / eclampsia
- Syphilis infection
- Urinary tract infections, frequent (>3 per year)
- Uterine cancer
- Vaginismus

Surgical History

Please list any surgeries you have had:

Is **vein access** a problem for you? Yes No

Family Medical History

Do you have a biological family history of the following? *If you do not know your family history, check here and move to the next section*

- Anesthesia complications
- Bleeding disorder
- Blood clotting disorder

Medications

Please list all prescribed and over-the-counter medications you take on a daily or weekly basis:

Medication Allergies

Please list all known allergies to medications with description of reaction:

CONTRACEPTIVE HISTORY

Were you using birth control when you got pregnant? Yes: _____ No

Have you used any of the methods below?

- Cervical cap Condom
- Diaphragm Emergency pill
- Fertility awareness Implant
- IUD Patch Pill
- Ring Shot (Depo) Sterilization
- Withdrawal

Are you interested in discussing pregnancy prevention today? Yes No

If yes, what method(s) are you most interested in? _____

PREGNANCY AND MENSTRUAL HISTORY

Please list the total number of each below:

Pregnancies (include current)	Births	Abortions (in the past)	Miscarriages	Living Children	Cesarean Births	Ectopic Pregnancies

Age at first period: _____ FIRST day of last period: _____

Was your last period normal? Yes No: _____

Are your periods regular? Yes: every _____ weeks for _____ days

No: _____

Do you want to get pregnant in the next 12 months? Yes No Unsure

PREVENTIVE HEALTH

Date of last Pap smear: _____

If eligible, are you interested in screening for cervical cancer today? Yes No

Have you had the HPV vaccine? Yes No If yes, how many doses? _____

SEXUAL HISTORY

What types of sex do you have?

- Vaginal Oral Anal

Have you had a new sex partner in the last 60 days?

- Yes No

Do you or any of your sex partner(s) currently have other sexual partners?

- Yes No Unsure

Do you use condoms or other barrier methods when having sex?

- Yes No Unsure

Are you interested in discussing medication to reduce your risk of getting HIV?

- Yes No Unsure

SOCIAL HISTORY

Do you use any of the following substances:

Tobacco, current use
Cigarettes/vape amount per day: _____

Tobacco, past use – quit date: _____

Alcohol – drinks per week: _____

Marijuana – Smoke Vape Edibles

Amount per week: _____

Other drugs – type _____

Amount per week: _____

Do you want referrals for any resources today (i.e. domestic violence, smoking, substance use, etc.)?

- Yes: _____ No

Do you have any safety concerns in your home, community, or workplace? Yes No

CONTACT INFORMATION

WHO IS YOUR DRIVER TODAY?

Name: _____

Phone: _____

Emergency Contact

Name: _____

Relationship to you: _____

Phone number: _____

Can we leave a voicemail here if we can't reach you first? Yes No

Preferred Pharmacy _____

Address: _____
