NAME:____ Client # ________________

Date of Birth :____________________ Age:______ Date:____________________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living Together

Are you currently: Student? ☐ Yes ☐ No Number of years completed ____________________

Employed? ☐ Yes ☐ No Occupation ____________________

Do you need a work/school excuse for Absence ☐ Yes ☐ No Lifting Restrictions ☐ Yes ☐ No

Health Care Provider ☐ None ☐ Planned Parenthood ☐ MD/Other (specify)____________________

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GENERAL HEALTH

Medical Issues in the last year: ☐ None ☐ Yes ____________________

Current medications (Rx/herbal)? ☐ None ☐ Yes ____________________

Medications taken today? ☐ None ☐ Yes List medication/ time taken : ____________________

Allergies & Reactions to latex or any medications? ☐ None ☐ Yes ____________________

____

Hospitalizations/Surgeries/Injuries ☐ None ☐ Yes ____________________

____

Pierced tongue? ☐ No ☐ Yes (instruct pt. to remove it)
Smoke cigarettes? ☐ No ☐ Yes Number of cigarettes daily #______
Drink alcohol? ☐ No ☐ Yes #____ / weekly monthly Did you drink alcohol in the last 12 hours? ☐ No ☐ Yes

Street drugs? ☐ No ☐ Yes ☐ Pot ☐ Cocaine/Crack ☐ Ecstasy ☐ Heroin ☐ Other ____________________

Most recent drug and when? ____________________

FAMILY HISTORY
Have your parents ever had: ☐ Heart attack before 50 ☐ High blood pressure ☐ High blood fat levels (i.e. cholesterol)
☐ Breast/Uterine cancer ☐ Diabetes ☐ None

PERSONAL HISTORY **STAFF COMMENTS**

Do you currently have or have you ever had:

8. Cancer	☐ None	☐ Past	☐ Now
9. Heart Disease/Problems/Murmur	☐ None	☐ Past	☐ Now
10. Rheumatic Fever/ German Measles	☐ None	☐ Past	☐ Now
11. High Blood Pressure	☐ None	☐ Past	☐ Now
12. Stroke	☐ None	☐ Past	☐ Now
13. Numbness/tingling in arms, hands, legs, feet	☐ None	☐ Past	☐ Now
14. Frequent/Severe headaches/migraines	☐ None	☐ Past	☐ Now
15. Fainting or dizzy spells	☐ None	☐ Past	☐ Now
16. Epilepsy/Seizures *note type/date of last episode	☐ None	☐ Past	☐ Now
17. Chest pain/ shortness of breath	☐ None	☐ Past	☐ Now
18. Asthma/Hay fever ☐ seasonal ☐ environmental	☐ None	☐ Past	☐ Now
19. Blood clots in the veins/Thrombophlebitis	☐ None	☐ Past	☐ Now
20. Sickle cell disease *last crisis date__________	☐ None	☐ Past	☐ Now
21. Stomach problems/ Ulcers	☐ None	☐ Past	☐ Now
22. Liver/ kidney/ inflammatory bowel disease	☐ None	☐ Past	☐ Now
23. Urinary tract/ bladder/ kidney infections	☐ None	☐ Past	☐ Now
24. Gall bladder disease ☐ removed: year____	☐ None	☐ Past	☐ Now
25. Hepatitis, jaundice or mononucleosis	☐ None	☐ Past	☐ Now
26. Leg cramps/Swollen feet or ankles/Varicose veins	☐ None	☐ Past	☐ Now
27. Anemia (low iron) or Bleeding disorder	☐ None	☐ Past	☐ Now
28. Thyroid disease	☐ None	☐ Past	☐ Now
29. Diabetes	☐ None	☐ Past	☐ Now
30. HIV/ AIDS / Immune Disorder	☐ None	☐ Past	☐ Now
31. Counseling/anxiety/depression problems	☐ None	☐ Past	☐ Now

REPRODUCTIVE HEALTH NAME:______________________________ Client # ____________

Have you ever had a pelvic exam? ☐ No ☐ Yes

Date of last Pap Smear (month/year) __________ Results: ☐ Normal ☐ Abnormal (see #1 below) ☐ Has never had a Pap Smear

GYNECOLOGICAL HISTORY

Menstrual Periods: ☐ Regular Every ________ days. ☐ Irregular Describe: ______________________________

Bleed # ______ days **Flow:** ☐ heavy ☐ medium ☐ light **Cramps:** ☐ none ☐ mild ☐ moderate ☐ severe **Use:** ☐ pads ☐ tampons

Do you have currently or have you ever had:

STAFF COMMENTS

1. Abnormal Pap Smear (APS) ☐ None ☐ Past ☐ Now
   If APS: ☐ Colposcopy ☐ Biopsy ☐ Cryosurgery ☐ LEEP ☐ No treatment
2. STI (gonorrhea/syphilis/chlamydia/HPV) ☐ None ☐ Past ☐ Now
3. Frequent vaginal infections ☐ None ☐ Past ☐ Now
4. Vaginal discharge/odor/sores/warts ☐ None ☐ Past ☐ Now
5. Frequent yeast infections/ itching ☐ None ☐ Past ☐ Now
6. Pelvic Inflammatory Disease (PID) ☐ None ☐ Past ☐ Now
7. Endometriosis ☐ None ☐ Past ☐ Now
8. Ovarian Cysts ☐ None ☐ Past ☐ Now
9. Uterine growths/ fibroids/ abnormalities ☐ None ☐ Past ☐ Now
10. Lower abdominal pain ☐ None ☐ Past ☐ Now
11. Pain/Bleeding with intercourse ☐ None ☐ Past ☐ Now
12. Spotting or bleeding between periods ☐ None ☐ Past ☐ Now
13. Premenstrual discomforts ☐ None ☐ Past ☐ Moody ☐ Breast Tenderness ☐ Bloating
14. Fibrocystic Breast Disease/lump ☐ None ☐ Past ☐ Now
15. Breast surgery/ nipple discharge ☐ None ☐ Past ☐ Now
16. Nausea/Vomiting with pregnancy ☐ None ☐ Past ☐ Now

PREGNANCY HISTORY

Have you been pregnant before? ☐ No ☐ Yes Total number of previous pregnancies: # ______

If yes: Vaginal births # ____ Caesarean births # ____ (Parenting # ______ Released for adoption # ______ Adopted #______)

Miscarriages # ____ Abortions # ____ Stillbirths # ____ Tubal Pregnancies # ____

Most recent delivery? (Month/year) ________________ Currently breast feeding? ☐ No ☐ Yes

Complications with pregnancies? ☐ None ☐ Toxemia ☐ Hemorrhaging ☐ Prematurity ☐ Diabetes ☐ ______________

CONTRACEPTIVE HISTORY

Most recent BC method? __________________ Used how long? ________ Problems? ______________________

	STAFF COMMENTS		STAFF COMMENT
☐ Birth Control Pill		☐ IUD	
☐ Ortho Evra Patch		☐ Diaphragm	
☐ Depo Provera Shot		☐ NuvaRing	
☐ Condoms		☐ Sponge	
☐ Spermicide		☐ Withdrawal	
☐ Emergency Contraception		☐ Tubal ligation	
		☐ Vasectomy	

MEDICAL ABORTION SECTION

(Completed only if client qualifies for and considering Medical abortion option)

Do you live with anyone? ☐ No ☐ Yes With whom? ______________________________

Do you live within 30 minutes of an emergency facility?	☐ No	☐ Yes
Do you have reliable transportation?	☐ No	☐ Yes
Are you willing to return to the clinic for all required visits (one-three)?	☐ No	☐ Yes
Do you have access to a telephone or cell phone?	☐ No	☐ Yes
Will you consent to have a surgical abortion if the medical abortion fails?	☐ No	☐ Yes
Can you speak and understand English?	☐ No	☐ Yes
Do you have a known intolerance to Mifepristone (Mifeprex), Misoprostol (Cytotec) or any prostaglandin medication?	☐ No	☐ Yes
Do you have chronic adrenal gland failure?	☐ No	☐ Yes
Are you currently taking Corticosteroids?	☐ No	☐ Yes
Do you have a bleeding disorder or currently taking blood thinning medication?	☐ No	☐ Yes
Do you have inherited Porphyria disorder?	☐ No	☐ Yes

To the best of my knowledge, the above information is complete and accurate.

Client Signature ______________________________________ **Date** ______________

Staff Signature ______________________________________ **Date** ______________

First Name _______________________ **Last Name** _______________________________ **Date** _________

Our goal is to provide you with as safe and as comfortable an abortion experience, physically and emotionally, as possible. A private counseling session is provided to evaluate and review your medical history, birth control options, coping skills, support system, abortion decision and procedure process. What you choose to share is up to you but be assured our goals are to provide you with support, inform you about what to expect, make sure this is *your* decision and prepare you to safely return home. Please help your counselor to make sure your needs are met by answering the following questions:

1. **Right now I feel**: (circle all that apply)

Relieved	**Fearful**	**Optimistic**	**Resentful**	**Confident**	**Cheated**	**Heartbroken**	**Sad**
Irritated	**Peaceful**	**Distrustful**	**Pressured**	**Surprised**	**Vulnerable**	**Irresponsible**	**Free**
Thankful	**Restless**	**Tormented**	**Sensitive**	**Challenged**	**Understood**	**Disillusioned**	**Tired**
Judged	**Liberated**	**Worried**	**Insecure**	**Preoccupied**	**Powerful**	**Appreciative**	**Cold**
Ashamed	**Rejected**	**Tearful**	**Desperate**	**Courageous**	**Comforted**	**Overwhelmed**	**Alone**
Hopeful	**Paralyzed**	**Helpless**	**Anxious**	**Supported**	**Nervous**	**Embarrassed**	**Lost**
Bitter	**Determined**	**Engaged**	**Cowardly**	**Energetic**	**Empty**	**Encouraged**	**Loved**
Selfish	**Empowered**	**Certain**	**Angry**	**Shaky**	**Guilt**	**Disinterested**	**Numb**
Secure	**Haunted**	**Wronged**	**Grief**	**Panicked**	**Accepting**	**Discouraged**	**Clear**

2. **On a scale from 1 (simple) to 10 (difficult), was this a clear and simple decision or a complicated and difficult one?**

clear/simple 1 2 3 4 5 6 7 8 9 10 complicated/difficult

3. **I am most concerned about:** (check all that apply)

- ☐ My decision
- ☐ Confidentiality
- ☐ My relationship with my partner
- ☐ How I'll feel emotionally afterwards
- ☐ How I'll feel during the procedure
- ☐ Possible complications during and after the abortion
- ☐ Religious or moral concerns
- ☐ Physical recovery afterwards
- ☐ Possible effects on future pregnancies
- ☐ Other ______________________________

4. **I've discussed this decision with my...**

- ☐ Male Partner
- ☐ Medical Professional
- ☐ Husband
- ☐ Counselor
- ☐ Family
- ☐ Other
- ☐ Friends
- ☐ No One

5. **I'm interested in knowing more about or using the following methods of birth control...**

- ☐ Birth Control Pills
- ☐ Depo Provera Injection
- ☐ Ortho Evra Patch
- ☐ Diaphragm
- ☐ Vaginal NuvaRing
- ☐ Male/Female Condom
- ☐ Spermicides
- ☐ Sterilization
- ☐ IUD

ABOUT CONSCIOUS SEDATION: Your counselor will explain the abortion procedure(s) appropriate for your length of pregnancy, including the medications we will use and the staff support you will receive. In the first trimester, a local anesthetic, an oral anti-anxiety medication, an anti-inflammatory medication and a pain relieving narcotic called Fentanyl are routinely used to provide pain relief during the procedure. In the second trimester, Conscious Sedation (a combination of Fentanyl and a sedative-hypnotic drug called Versed) are used to lower your level of consciousness, helping you to feel more relaxed and experience less discomfort and less anxiety during the procedure.

Conscious Sedation is also offered as an option in the first trimester so if you are experiencing a level of anxiety so high you believe it will interfere with your ability to cope during the procedure, or you suffer from an extremely low pain tolerance. You are only eligible for Conscious Sedation if you have not eaten or drank anything (*nothing* by mouth) after midnight the night before your appointment and you are financially prepared on your own or through funding with the additional $75 fee.

Although conscious sedation does carry minimal risks, it provides you with increased sedation without the high risks associated with general anesthesia by allowing you to maintain your breathing independently, be easily aroused, and respond to physical stimuli and verbal commands. We will screen you for any medical conditions which may prohibit the use of conscious sedation and answer all of your questions before you consent to its use.