



Do **you** have any allergies? Yes No If Yes please list: _____

Has a doctor ever told you that you should not take anti-inflammatory medication? Yes No

Have you had any serious reactions to anesthesia? Yes No

If yes, please describe: _____

Do you take any medications? Yes No If yes, please list: _____

Have you had a Pap test? Yes No If yes, when: _____

Do you smoke? Yes No

Please check off any of the following conditions you currently have, or have had in the past

- | | | |
|--|--|--|
| <input type="checkbox"/> Blood disorder(s) | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stomach ulcer/Crohn's disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Blood clot leg, lung, brain | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Uterine irregularity |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraines | <input type="checkbox"/> IUD currently in place |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Adrenal disease | <input type="checkbox"/> Currently taking Methadone |
| <input type="checkbox"/> Other: _____ | | |

Please give details for those items you have checked: _____

Family history

- Breast cancer before the age of 50
- Clotting disorder
- Bleeding disorder

Pregnancy History

Please enter the **number of times** you have experienced the following

Pregnancy	
Vaginal Birth	
C-Section	

Ectopic (tubal) pregnancy	
Miscarriage	

Abortion	
Other	

Please check off any of the following which apply **during this pregnancy**

- Breastfeeding
- Vaginal bleeding
- Vomiting (how many times per day)

Please list any non-prescription drugs, recreational drugs, herbs and alcohol you have taken in the last 24 hours: _____

Please list what you have had to eat and drink today, and the what time you had them:

This section to be completed by Nurse

Contraceptive Eligibility

Client is eligible for:

All contraception

The Following contraception options are excluded based on medical history:

- Hormonal (estrogen) IUD
 Hormonal (progesterone) Latex Condoms

Medical Abortion Eligibility

- No contraindications in medical history for medical abortion
 Eligible and interested in Medical abortion
 Eligible but not interested in Medical abortion
 Not eligible for Medical abortion - Having surgical

Notes: _____

Reviewed by: RN _____ MD _____