

Patient's Name (Last, First) _____ Patient's Date of Birth _____

Patient's Address _____ Patient's Phone Number _____

 Date of Appointment: _____ Location: Billings Great Falls Helena Missoula

PATIENT SCREENING QUESTIONS

 Date of Last Menstrual Period _____ Was it Normal? Yes No

Do you have, or have you ever had, any of the following Medical Conditions?

1. Severe Anemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. A bleeding disorder or a clotting disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Heart attack, heart disease, or stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. High blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Asthma or other breathing problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Disease or problems with kidneys, liver, adrenal glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Epilepsy or seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Any other chronic or serious illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you been pregnant before? Living _____ AB _____ Miscarriage _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you ever had a cesarean section (c-section)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Any other pelvic or abdominal surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Do you have an IUD in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Are you nursing an infant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Any vaginal bleeding or discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Depression/anxiety?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Do you drink alcohol? If yes, how many drinks a day _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Do you use non-prescription or street drugs? If yes, please list what drugs and how often: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

 19. Do you know your HIV status? Yes No

MEDICATION		ARE YOU ALLERGIC TO:	
Are you taking any anticoagulants?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mifepristone, Misoprostol, other prostaglandins?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any steroids?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Local Anesthetics?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Iodine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please list them:		Doxycycline?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Latex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Pain Medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Any other allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Please list them:	

FOR MEDICATION ABORTION ONLY

20. Do you have a support person to help if necessary?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Do you have access to an emergency facility in your community?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Do you have reliable transportation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Will you have access to a phone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
24. Are you willing to have a surgical abortion if that is necessary?	<input type="checkbox"/> Yes <input type="checkbox"/> No
25. Will you be able to travel back to the clinic for a follow-up visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Client Signature _____ Date _____

***** You will need to have an email address, either through an internet email account (hotmail, yahoo, Gmail etc), Outlook Express or Outlook to email this form. If you're using an internet email account, you will need to save the form to your computer, then email it as an attachment to heights@ppmontana.org*****

Staff Signature _____ Date _____

Provider Signature _____ Date _____

Name _____ Date of Birth _____ Chart Number _____

****If you're considering Birth Control Pills after your abortion please answer the following questions****

Patient's Name (Last, First) _____ Patient's Date of Birth _____
 Patient's Address _____ Patient's Phone Number _____

PATIENT BCM SCREENING QUESTIONS

Do you have, or have you ever had, any of the following Medical Conditions?

1. Blood clots or a clotting disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. A Stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. High Cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Heart disease or heart valve problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Headache or Migraines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Gallbladder disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Breast Cancer or lumps in your breast?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Other Cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list what kind:	
9. If you're over 40yo, did you have a breast exam or mammogram in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Lupus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Any other serious illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Any surgery to lose weight?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. An organ transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Problems with vaginal muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Problems with constipation and/or diarrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Problems with your bones?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. An eating disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Did anyone in your family have a heart attack or stroke before age 65?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Does anyone in your family have a blood clotting disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Are you a smoker or do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Are you planning a major surgery that will require long-term bed rest?	<input type="checkbox"/> Yes <input type="checkbox"/> No
MEDICATION	
22. Are you taking any herbal medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list them:	

Client Signature _____ Date _____

******* You will also need to have an email address, either through an internet email account (hotmail, yahoo, Gmail etc), Outlook Express or Outlook to email this form. If you're using an internet email account, you will need to save the form to your computer, email it as an attachment to heights@ppmontana.org *******

STAFF USE ONLY:

Comments _____

Staff Signature _____ Date _____

Provider Signature _____

Name _____ Date of Birth _____ Chart Number _____