

Name _____ Date _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Thank you for answering this personal information, it allows us to provide you with the best care possible. All information is private according to our HIPAA privacy policy.

<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you have an IUD (IUC) in right now?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever been diagnosed with migraines?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had heart disease, a heart valve problem, or high blood pressure?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had breast cancer or other breast disease?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had liver or kidney (renal) disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you have a seizure disorder or history of seizures?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you have an immune deficiency or have you had lupus?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had an abnormal Pap test?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you have a blood clotting disorder (bleeding too much <u>or</u> clotting too much)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had thyroid disease (hypo thyroid or hyperthyroid)?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you recently had a sexually transmitted infection or pelvic inflammatory disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Are you diabetic?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had an infection in your uterus, fallopian tubes, or ovaries?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had asthma? If yes, when was your last attack: _____
<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you have a history of blood clots in your veins, lungs, or brain (stroke)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had depression or anxiety disorder?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you have an abnormally shaped uterus or fibroids?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you used drugs or alcohol in the last 24 hours?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Are you currently breastfeeding?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you use tobacco (cigarettes, chew, cigars)?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Have your parents, brothers, or sisters had a heart attack, stroke, or heart disease before age 55 (early heart disease)?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you had any other major medical problems or major surgery? If Yes, what: _____		

Planned Parenthood can help women who have concerns or a history of sexual assault, rape (including date rape), physical abuse, domestic violence or emotional/mental health issues. We can help you if you are in a situation in which any of these are occurring or have occurred.

<input type="checkbox"/> No <input type="checkbox"/> Yes	Is anyone forcing you to do anything in your life, including being here today?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you currently feel safe in your relationship and living situation?
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PREGNANCY HISTORY

When was the first day of your last period? ___/___/___ How many pregnancies have you had (including today) _____
 How many: Births _____ Miscarriages _____ Abortions _____ Ectopic/Tubals _____ C-Sections _____

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<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you have an IUD (IUC) in right now?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Are you diabetic?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Are you able to return for follow up to make sure the pregnancy has ended?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had an eating disorder?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Are you willing to have an in clinic abortion procedure if the medication does not work?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had gallbladder disease?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you have access to a telephone and a way to get to an emergency room if needed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had high cholesterol or high blood pressure?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you used drugs or alcohol in the last 24 hours?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had liver disease?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Are you currently breastfeeding?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever been diagnosed with migraines?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had osteoporosis?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had a heart attack?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had an abnormal Pap test?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had a blood clot in your lung (pulmonary embolus)?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had bariatric surgery?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you have a seizure disorder or a history of seizures?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had breast cancer or a breast mass/lump?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had lupus (SLE)?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had any other type of cancer?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you have a blood clotting disorder (clotting too much)?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had a stroke or blood clot in your vein(s)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had a heart valve problem or heart disease?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you ever had depression?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you use tobacco (cigarettes, chew, cigars)?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Have you had any other major medical problems or major surgery? If Yes, what: _____		
<input type="checkbox"/> No <input type="checkbox"/> Yes	Have your parents, brothers, or sisters had a heart attack, stroke, or heart disease before age 55 (early heart disease)?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	If you are under 18, is there an adult who knows you are here today?		
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