Planned Parenthood of Montana

Patient Screening Questions

Date of Last Menstrual Period _____ Was it Normal? ❑Yes ❑ No	
_____ Total # of Pregnancies _____ Number of live births _____ Number of Abortions _____ Number of Miscarriages _____ Number of Tubal Pregnancies	Date of Last Delivery: _____ Date of Last Abortion: _____ Any complications? _____ Have you ever had a cesarean section (c-section)? ❑Yes ❑No
❑Yes ❑No	Are you breastfeeding?
❑Yes ❑No	Do you have an IUD in place?
Are you allergic to:	
❑Yes ❑No	Mifepristone, Misoprostol, other prostaglandins
❑Yes ❑No	Local Anesthetics
❑Yes ❑No	Iodine
❑Yes ❑No	Doxycycline
❑Yes ❑No	Azithromycin (Zithromax)
❑Yes ❑No	Metronidazole (Flagyl)
❑Yes ❑No	Latex
❑Yes ❑No	Pain Medication
❑Yes ❑No	Any other allergies? If yes, please list them:
Medications	
❑Yes ❑No	Are you taking any anticoagulants?
❑Yes ❑No	Any steroids?
❑Yes ❑No	Any other medications? (Including herbal medications) If yes, please list them:
Do you have, or have you ever had, any of the following medical conditions? *(Family Practice)*	
❑Yes ❑No	Anemia
❑Yes ❑No	Anxiety
❑Yes ❑No	Asthma or other breathing problem
❑Yes ❑No	Blood clots
❑Yes ❑No	Breast Cancer
❑Yes ❑No	Other Cancer If yes, please list what kind:
❑Yes ❑No	Depression
❑Yes ❑No	Diabetes Age at diagnosis _____
❑Yes ❑No	High Cholesterol
❑Yes ❑No	Gallbladder problems
❑Yes ❑No	Headache or Migraine
❑Yes ❑No	Heart disease or heart valve problem
❑Yes ❑No	Liver problems (Hepatitis, liver disease, tumor, etc.)
❑Yes ❑No	High blood pressure
❑Yes ❑No	Heart attack (Myocardial infarction)
❑Yes ❑No	Problems with your bones (Osteoporosis)

NAME _____ DOB: _____ Chart#: _____

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❑Yes ❑No	Kidney problems (Renal disease)
❑Yes ❑No	Seizures/epilepsy (Seizure disorder)
❑Yes ❑No	Stroke or stroke like problems
❑Yes ❑No	Breast lump or mass *(Gynecology)*
❑Yes ❑No	Bruising/bleeding disorder
❑Yes ❑No	Clotting disorder
❑Yes ❑No	Heart murmur
❑Yes ❑No	Stomach problems *(Other)*
❑Yes ❑No	Disease or problem with adrenal glands
❑Yes ❑No	Lupus
❑Yes ❑No	Eating disorder (anorexia, bulimia)
❑Yes ❑No	Other medical problem or diagnosis
❑Yes ❑No	Have you had any pelvic or abdominal surgery?
❑Yes ❑No	Any surgery to lose weight?
❑Yes ❑No	An organ transplant?
❑Yes ❑No	Are you planning major surgery that will require long-term bed rest?
❑Yes ❑No	If you're over 40yo, did you have a breast exam or mammogram in the past year?
❑Yes ❑No	Did anyone in your family have a heart attack or stroke before age 65?
❑Yes ❑No	Does anyone in your family have a blood clotting disorder?
❑Yes ❑No	Are you a smoker or do you use tobacco? If yes, how many cans/wk or cigs/day_____
❑Yes ❑No	Do you drink alcohol? If yes, how many drinks a day_____
❑Yes ❑No	Do you use non-prescription or street drugs? If yes, please list what drugs and how often:
❑Yes ❑No	Do you know your HIV status?
❑Yes ❑No	Do you have any vaginal bleeding or discharge?
For Medication Abortion Only	
❑Yes ❑No	Do you have a support person to help if necessary?
❑Yes ❑No	Do you have access to an emergency facility in your community?
❑Yes ❑No	Do you have reliable transportation?
❑Yes ❑No	Will you have access to a phone?
❑Yes ❑No	Are you willing to have a surgical abortion if that is necessary?
❑Yes ❑No	Will you be able to travel back to the clinic for a follow-up visit?
Ultrasound questions	
You will receive an ultrasound examination today. It will be done only to determine the age of the pregnancy. Some women want to see the ultrasound image, others do not. Sometimes multiple pregnancies are seen. Some women want to be told this, others do not. We are completely supportive of any decision. Please let us know your preferences by checking the appropriate boxes below.	
❑Yes ❑No	I would like to see the ultrasound image
❑Yes ❑No	I would like to be told if multiple pregnancies are seen

NAME _____ DOB: _____ Chart#: _____