Medical, Social and Pregnancy History (Revised Feb 12/20) Date:_____

Health Card #_____

First Name:_____ Last Name: _____ DOB:_____

*****COMPLETE AND TAKE TO YOUR APPOINTMENT*****

Please answer in **INK** accurately and completely.

This information is important to provide you with high quality and safe care.

1. Do you have any allergies? ☐Yes ☐No If yes, explain _____

2. Are you on any medications (prescription or over the counter), inhalers, vitamins, or herbal supplements?

☐Yes ☐No If yes, list_____

3. Have you had any of these medical conditions?

☐ Bleeding or blood clotting problems
☐ Anemia

☐ Migraines

☐ Chronic Adrenal Failure
☐ Inherited Porphyrias

☐ Epilepsy/seizures

☐ Stomach problems
☐ Bowel problems

☐ Asthma
☐ Sleep Apnea
☐ Diabetes

☐ Heart conditions
☐ Kidney disease
☐ Liver disease

☐ Hepatitis B, C or HIV
☐ HPV/Genital Warts
☐ Chlamydia
☐ Trichomonas
☐ Genital Herpes
☐ Gonorrhea

☐ Depression
☐ Anxiety

☐ Other _____
☐ No medical problems

4. Are you currently breastfeeding? ☐Yes ☐No

5. Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, explain _____

6. Have you ever had an operation? ☐ Yes ☐ No If yes, list _____

7. Do you have any medical conditions not mentioned or been in the hospital for any other reasons?

☐ Yes ☐ No If yes, explain _____

8. Have you or anyone in your family had:

Blood clots in the legs or lungs? ☐Yes ☐No If yes, explain _____

Bleeding disorders (ie. hemophilia, von willebrand's) ? ☐Yes ☐No

If yes, explain _____

Serious reactions to anesthetics? ☐Yes ☐No If yes, explain _____

9. Do you use nicotine/smoke cigarettes? ☐ Yes ☐ No If yes, how much per day? _____

10. Do you use marijuana? ☐ Yes ☐ No If yes, explain _____

11. Do you use street drugs? ☐ Yes ☐ No If yes, explain _____

12. Do you drink alcohol? ☐ Yes ☐ No
If yes, how much and how often? _____

13. When was your last Pap test?
☐ I don't know what a Pap test is
☐ Never had one
☐ Less than 3 years ago
☐ More than 3 years ago
Have you ever had an abnormal Pap? ☐ Yes ☐ No If yes, explain _____

14. Is this your first pregnancy?
☐Yes (if yes, go to question #14)
☐No (if no, answer the following questions)
Do you have any children? ☐Yes ☐No If yes, how many? _____
Have you ever had a tubal or ectopic (outside the uterus) pregnancy? ☐Yes ☐No

Have you ever had a miscarriage? ☐Yes ☐No If yes, how many?_____
Have you ever had an abortion? ☐Yes ☐No
If yes, when? _____, where?_____

15. What was the first day of your last normal period? _____

16. Have you had any bleeding or cramping since your last period? ☐ Yes ☐ No

If yes, explain _____

17. Have you been well during this pregnancy? ☐ Yes ☐ No

If no, explain _____

18. Do you have any concerns regarding this pregnancy? ☐ Yes ☐ No

If yes, explain _____

19. Are you aware that you have three options available to you in an unintended pregnancy?
Adoption, parenting and abortion. ☐ Yes ☐ No

20. For what reason(s) are you considering/choosing abortion?
☐ I do not want a child right now
☐ I have all the children I want
☐ I want to work/continue school
☐ I am too young/old
☐ Illness/medical problems
☐ Insufficient money
☐ My parents want the abortion
☐ My partner wants the abortion
☐ My spouse/regular partner is not the person by whom I am pregnant
☐ Pregnancy is result of a sexual assault
☐ Other: _____

21. My feelings about having an abortion are:
☐ I am definite in my thinking and feeling
☐ I have some conflicts with my decision
☐ I have serious conflicts with my decision
_____
_____

22. The person by whom I am pregnant is:
☐ Spouse/Common Law/Partner (living together)
☐ Partner (not living together)
☐ Friend/Acquaintance
☐ Uncertain
☐ Other _____

23. Is your relationship with this person continuing? ☐ Yes ☐ No ☐ Uncertain

24. Their feelings about this pregnancy and/or abortion are:
- ☐ They would like me to continue the pregnancy
- ☐ They feel abortion is the best decision
- ☐ They do not know about the pregnancy and/or abortion
- ☐ I feel it is my own decision
- ☐ I feel they are supportive in whichever choice I make

25. Who have you discussed your situation with?

☐ Partner/Spouse _____ ☐ Professional counselor_____

☐ Family member(s) _____ ☐ Religious advisor_____

☐ Friend(s)_____ ☐ Other _____

26. Would you like to meet with a professional counselor to help you with your feelings about your pregnancy, your options and your decision? ☐ Yes ☐ No
(Refer to "Pregnancy Options Resources" handout)

27. If you are choosing abortion, do you have a preference regarding the method?
- ☐ Yes ☐ No ☐ Unsure

If Yes, please indicate
- ☐ Surgical -up to 12 weeks 0 days (free with provincial health card, excluding Quebec)
- ☐ Medical -up to 10 weeks 0 days (free with Saskatchewan health card)

(Refer to "Comparison of Early Abortion Options" handout. Preference does not guarantee eligibility for or availability of method.)

27. Were you and your partner using a method of birth control?

☐ Yes ☐ No If yes, specify type: _____

28. What birth control methods have you used in the past?
- ☐ Birth control pills
- ☐ Condoms
- ☐ Depo-Provera injection
- ☐ Nuvaring vaginal ring
- ☐ Evra patch
- ☐ Morning after pill/Plan B
- ☐ IUD, Copper or Hormones
- ☐ Spermicidal foam and jelly
- ☐ Diaphragm/Cervical Cap
- ☐ None

29. What problems have you had with the type of birth control you have used?

_____

30. Who is your family doctor/nurse practitioner/usual primary care provider? _____

31. Including your primary care provider in communications about your health care may improve care continuity, quality and safety. (Refer to "Privacy of personal information" handout.) Do you agree to information about your health care being shared with your primary care provider? ☐ Yes ☐ No

32. Is there any additional information you would like us to know?

☐ I confirm the information on this form is complete and accurate.

Signature: _____ Completed by: ☐ Self ☐ Interpreter ☐ Nurse