

**Medical, Social and Pregnancy History** (Revised Dec 18/18) Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Please answer 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 smoke cigarettes?  Yes  No If yes, how many per day? \_\_\_\_\_

10. Do you use street drugs?  Yes  No If yes, explain \_\_\_\_\_

11. Do you drink alcohol?  Yes  No

If yes, how much and how often? \_\_\_\_\_

12. 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 \_\_\_\_\_

13. 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? \_\_\_\_\_

14. What was the first day of your last normal period? \_\_\_\_\_

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

If yes, explain \_\_\_\_\_

16. Have you been well during this pregnancy?  Yes  No

If no, explain \_\_\_\_\_

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

If yes, explain \_\_\_\_\_

18. Are you aware that you have three options available to you in an unintended pregnancy?

Adoption, parenting and abortion.  Yes  No

19. 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: \_\_\_\_\_

20. 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

\_\_\_\_\_

\_\_\_\_\_

21. The person by whom I am pregnant is:

- Spouse/Common Law/Partner (living together)
- Partner (not living together)

Friend/Acquaintance

Uncertain

Other \_\_\_\_\_

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

23. 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 \_\_\_\_\_
- Family member(s) \_\_\_\_\_
- Friend(s) \_\_\_\_\_
- Professional counselor \_\_\_\_\_
- Religious advisor \_\_\_\_\_
- 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 9 weeks 0 days (\$350-400, covered by some drug plans. If you do not have coverage and are unable to afford, you may be eligible for one time emergency drug assistance that covers up to 90% of the cost of the medication)

(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?

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

Signature: \_\_\_\_\_ Completed by:  Self  Interpreter  Nurse