PARTNERS IN ABORTION CARE

Patient Name: _____ *DOB:* _____ *MRN:* _____ *(Rev 3/2025)*

DEMOGRAPHICS AND MEDICAL HISTORY

PLEASE COMPLETE THIS ENTIRE FORM. Do not leave anything blank.

Your legal first and last name: _____

What name would you like us to use? _____ **Date of Birth:** _____/_____/_____
month day year

What pronouns would you like us to use? ☐She/her ☐He/him ☐They/them ☐Other: _____

Phone #: _____-_____-_____ **Email:** _____

Can we leave voicemail at this number? ☐Yes ☐No Can we email you at this address? ☐Yes ☐No

Can we text this number? ☐Yes ☐No

Home address: _____
Street Address

_____
City County State Zip Code

Birthplace (state, territory, or foreign country): _____

Where are you staying during your visit?

Hotel Name: _____ Room Number: _____

Home/other (please include drive time): _____

How will you get to/from the office? ☐I'm driving ☐I have a driver ☐Uber/Lyft

First and last name of the person accompanying you: _____

Relationship to you: _____ Their phone #: _____-_____-_____

Does this person know why you are here? ☐Yes ☐No

Emergency contact person that we can call in the event of an emergency. We may need to share limited but necessary medical information about your visit.

☐Check here if this is the same person accompanying you, or complete below:

First and last name of emergency contact: _____

Relationship to you: _____ Their phone #: _____-_____-_____

Does this person know why you are here? ☐Yes ☐No

Do you or your support person need a work/school note? ☐Yes - Please see the front desk ☐No

Have you ever been told you are anemic or have low iron: ☐Yes ☐No

Do you know your blood type: ☐Yes, my blood type is: _____ ☐No

Have you ever received a Rhogam shot during pregnancy or after a delivery, c-section, or abortion:

☐Yes ☐No

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ALLERGIES - Are you allergic to any medications, latex, iodine, or anything else?

☐Yes - I am allergic to: _____

☐No - I do not have any allergies to any medications, latex, iodine, or food.

MEDICATIONS - Do you take any prescriptions, over-the-counter medications, vitamins, or supplements?

☐Yes - I take: _____

_____

☐No - I do not take any prescriptions, over-the-counter medications, vitamins, or supplements.

PREGNANCY HISTORY

How many times you have been pregnant (including today): _____

My most recent period started on: _____ ☐I don't know/don't remember

	How Many?	What year(s)?	Staff notes only
Vaginal delivery			
C-section delivery			
Miscarriage			
Abortion procedure			
Abortion pill			
Ectopic pregnancy			

Did you have any complications or problems during or after any past pregnancy?

☐I have never been pregnant before ☐No problems or complications

☐Preeclampsia or high blood pressure in pregnancy ☐Hemorrhage (very heavy bleeding)

☐Preterm labor ☐Precipitous (very fast) labor/birth ☐Very low platelets

☐Other:_____

Do you know about any problems/complications for you or for the fetus in this pregnancy?

☐Yes, I have been told about the following problem(s):

_____

☐No problems or complications that I know about

SURGICAL HISTORY

Have you ever had surgery?

☐Yes, I have had the following surgeries:

_____

☐No - I have never had any kind of surgery

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MEDICAL HISTORY

Have you ever had any of these health problems?

	Yes	No
Anesthesia Reaction		
Epilepsy or seizures		
Asthma		
Sleep apnea		
Snoring or been told you gasp or stop breathing when sleeping		
Heart problems		
Bleeding or clotting problems		
Stroke, mini stroke, or TIA		
Lupus		
Sickle cell disease		
High blood pressure		
Diabetes		
Kidney problems		

	Yes	No
Problems with uterus like fibroids or unusual shape		
Thyroid problems		
Breast lump or mass		
Psychosis or hallucinations		
Other mental health problems		
Migraines		
Headaches with vision changes or numbness/tingling		
HIV		
Sexually transmitted infection		
Hepatitis/Liver problems		
Gallbladder problems		
Cancer or tumor		
Other: _____		

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SUBSTANCE USE HISTORY

This information helps us give you the safest, most comfortable care possible. Your answers will NOT affect your ability to be seen by us.

	Used this in the last 2 weeks	Used this more than 2 weeks ago	Never used
Nicotine (cigarettes, vape, pipe, cigars, or chew)			
Alcohol			
Marijuana/weed			
Benzodiazepines (medications such as Xanax, Ativan, Valium)			
Cocaine			
Amphetamines (meth, crystal, or medications for ADHD such as Adderall, Vyvanse, Ritalin)			
Opioids (heroin, methadone, Suboxone, Subutex, buprenorphine, Percocet, Vicodin)			
Ketamine (including Special K, monitored therapy, Spravato)			
Other: _____			

Do you have a FAMILY HISTORY of any of the following:

☐I do not know my family history (skip to next question)

	YES	NO	If yes, who in your family?
Bleeding or clotting problems			
Blood clots in legs or lungs			
Breast, uterine, or ovarian cancer			
Problems with anesthesia			
Heart attack or stroke before age 65			

Have you had any of these symptoms in the last 2 weeks?

	Yes	No
Chest pain		
Trouble breathing		
Dizziness		
Fever/chills		
Vaginal bleeding, pain with penetration, bothersome discharge		
Abdominal (belly) pain		

	Yes	No
Headache or migraine		
Feet or legs swelling		
Seeing spots, sparkles or other vision changes		
Nausea or vomiting (throwing up)		
Joint or muscle pain		
Rashes or unexplained bruising		

Is there anything else we should know about you or your health?

☐Yes:_____

☐No, nothing else I think you should know

Would you like to talk about birth control options while you are here?

☐Yes, I have used the following birth control in the past: _____

☐No, I have no need for birth control at this time

Would you like to discuss keepsake options? An example could be things like ultrasound pictures.

☐Yes

☐No

☐ I would like more information

I affirm that the information I have provided is complete and accurate.

Patient Signature:_____ Date: _____/_____/_____
(month) (day) (year)

Staff review signature:_____ Date: _____/_____/_____
(month) (day) (year)

Provider review signature:_____ Date: _____/_____/_____
(month) (day) (year)