Patient Name _____ Pronoun _____ Age _____

CONTRAINDICATIONS Date_____ You cannot do the medication abortion if you cannot return for any subsequent visits here and/or are unable to easily get emergency medical help in the 2 weeks after you take mifepristone . Are you able to return to NFP Y N Are you able to get emergency medical help Y N

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Do you have or have you ever had the following?:

	YES	NO		YES	NO
Allergy to Mifepristone or Misoprostol, Cytotec or other prostaglandin	❑	❑	Inherited porphyrias	❑	❑
Any medical condition that requires you to take "blood thinners" i.e. Asprin, Coumadin (Warfarin) or Heparin	❑	❑	IUD in place	❑	❑
Blood clotting disorders	❑	❑	Known or suspected pregnancy out of the uterus (ectopic)	❑	❑
Chronic Adrenal Failure	❑	❑	Long term use of corticosteroids	❑	❑
Heart disease that is AHA class 3 or higher	❑	❑	Seizure disorder or epilepsy that is not controlled	❑	❑
			Sickle cell anemia, leukemia, or thalacernia	❑	❑

HISTORY

	YES	NO		YES	NO		YES	NO
Anemia	❑	❑	Glaucoma	❑	❑	Migraine Headaches with Aura	❑	❑
Blood/Bleeding Disorder/Disease	❑	❑	Gonorrhea/Syphillis/Chlamydia	❑	❑	Pelvic Inflammatory Disease	❑	❑
Cancer Type _____	❑	❑	Hepatitis Type A B C	❑	❑	Rheumatic Fever	❑	❑
Diabetes	❑	❑	High Blood Pressure	❑	❑	Sickle Cell Trait/Disease	❑	❑
Fibroid Uterus	❑	❑	HIV+/AIDS	❑	❑	TB	❑	❑
Genital Warts	❑	❑	Liver Condition	❑	❑	Pulmonary Embolism/Deep Vein-Thrombosis (BloodClot)	❑	❑
						Ulcers	❑	❑

Do you have asthma? Y N If yes, most recent hospital visit_____

What medication is used with your inhaler?_____ Did you bring your inhaler? Y N

Explanation of above or other problems not listed: _____

_____

When was your last normal period? _____ How far along in the pregnancy do you think you are? _____

Number of births_____ Miscarriage(s)_____ Ectopic(s)_____ Abortion(s)_____ (_____)

Vaginal deliveries_____ # C-Sections_____ Have you ever been told you always have to have a C-section? Y N

Any Problems? Y/N If yes please explain _____

SOCIAL BEHAVIORS

Marijuana use Y N Last used_____ Recreation drug use Y N Type of drug(s)_____ Dependence Y N

Prescription pain medication abuse Y N Type of medication_____ Last taken _____

Alcohol use Y N Socially / Moderately / Dependent Do you smoke anything Y N What? _____ Amount_____

HOSPITAL/SURGERY

Any surgery on cervix? _____ Other surgeries(type: dates) _____

History of ectopic pregnancy Y N if yes, treatment with surgery / medication (circle)

Hospitalizations Y N Details _____

Have you had a C-section? Y N At what length of pregnancy? _____ Have you ever been told you always have to have a C-section? Y N

Have you ever been told by a physician that your uterus or reproductive organs are abnormal? (i.e. bicornate uterus) _____

_____

MEDICATION

Are you currently under a doctor's care? Y N Reason_____

Current medication(s) _____

For _____

Any medication or drugs taken in the past 24 hours _____

Allergies and/or reactions to drugs, medication, or sedation/analgesia or anesthetic technique? Y N Type of reaction _____

Skin reactions to Betadine/Iodine Y N _____

Are you taking any herbal supplements? Y N _____

MENTAL HEALTH

Treatment for mental illness- including depression, bi-polar, mood disorders, anxiety Y N Details_____

Psychiatric, psychological or social work evaluation or treatment Y N Details _____

Anger management issues Y N Details _____

MISCELLANEOUS

Do you have an advanced directive? ____Yes ____ No If yes, please specify _____

In regard to the above check list, do any of these apply to your immediate family (mother, father, brother, sister) _____

_____

List previous birth control methods used _____ Type(s) interested in for the immediate future _____

Did you become pregnant while using birth control? Y N If yes, what type and brand name? _____

I have completed the History Section and it is accurate to the best of my knowledge.

_____ _____

(Patient Signature) (Witness Signature)

_____ _____

Rtn date Staff Signature