**WOMAN’S HEALTH OPTIONS**

## IDENTIFICATION FORM / FOR PROCEDURE

Date:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Time: \_\_\_\_\_\_\_\_\_\_\_\_\_



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

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Pronoun: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Street)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(City/Town) (Province/Country) (Postal Code)**

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day Month Year

Telephone No.: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Home) (Business)

Telephone Number (other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your first language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver Name/Ph\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Phone Number)

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

### FOR OFFICE USE ONLY

File No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ U/S Fee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Receipt No. U\S \_\_\_\_\_\_\_\_\_\_

Paid: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Receipt No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Balance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Depo Evra Nuvaring IUD Visa Cash MC Debit

Province: AB BC SK MB ON NT NU YT NB NS PEI NL RCMP D.N.D. Immigration Visa Cash MC Debit

FAC 87.29A/635 87.29B/635 BM X317 X320 X318 13.99BA/622.1 13.99BE/622.1 03.03A/V26.4

03.04A/V25.9 03.08A/V25.0 81.8/V25.1 87.0A/635 79.29E/622.8 (Biopsy) 79.29E/622.7 (Polyp) 13.59A/626.8

Date appointment booked: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL HISTORY

1. Circle present symptoms of pregnancy: Frequent Urination – Enlarged Breasts – Nausea – Vomiting – Heartburn

2. Did you use Plan B (Morning after pill) to try and prevent this pregnancy? Y / N

3. If it were discovered that you were pregnant with twins would you want to know? Y / N

4. How many previous pregnancies have you had? \_\_\_\_\_\_\_\_.

5. How many children do you have? \_\_\_\_\_\_\_\_\_\_\_. What are their ages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you presently breastfeeding? Y / N

Did you have any problems with previous pregnancies? Y / N If yes, what were they\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. How many vaginal deliveries have you had? \_\_\_\_\_\_\_\_\_\_\_

7. Have you had any previous cesarean sections? Y / N If yes, why \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Have you ever had a miscarriage? Y / N If yes, how many \_\_\_\_\_\_\_\_\_\_

9. Have you ever had an ectopic pregnancy (tubal pregnancy)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Have you ever had an abortion before? Y / N If yes, where and when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Have you ever had a pap smear / pelvic exam before? Y / N

If yes, when was your last pap smear? \_\_\_\_\_\_\_\_\_\_\_

Have you ever had an abnormal pap smear? Y / N

Have you ever had pelvic inflammatory disease or endometriosis? Y / N

Have you ever had an STI (sexually transmitted infection)? Y / N If yes, was it treated? Y / N

12. Would you like us to test for Bacterial Vaginosis, Gonorrhea, and Chlamydia? Y / N

Would you like a Pap Smear (cervical cancer screening)? Y / N

Would you like us to test for Syphilis today? Y / N

If yes, provide a phone number or email address where you can be contacted. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**You will only be contacted if results are positive**.

13. Have you ever had a HPV vaccine? Y / N If so when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like information on that today? Y / N

14. If you are receiving a Depo injection today, when was your last injection? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15. Have you ever been admitted to a hospital before? Y / N If yes, what for\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16. Have you ever had surgery on your Uterus, Fallopian Tubes or Cervix? Y / N

If yes, what type of surgery? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. Have you ever had or do you have any of the following (please circle)? **None** – Epilepsy – Diabetes – Anemia

High Blood Pressure – Asthma/Hay Fever – Von Willebrand Disease – Bleeding Problems – Hepatitis – Thyroid

HIV – AIDS – Inflammatory Disease – Renal – Ulcers and Heart Burn – Rapid / Irregular / Heart Rate – Crohn’s

Ulcerative Colitis – Hyper emesis – Liver – Immune Thrombocytopenic Purpura – Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18. Have you experienced any of the following (please circle)? **None** – Depression – Anxiety / Panic Attacks – Bi-Polar

FASD – ADHD – ADD – Post Partum Depression – Schizophrenia – Anorexia / Bulimia – PTSD

19. Do you have any allergies that you are aware of? Y / N If yes, see below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Allergy** |  | **REACTION** | **ALLERGY** |  | **REACTION** |
| Penicillin | Y N |  | Sulfa | Y N |  |
| Tetracycline | Y N |  | Flagyl | Y N |  |
| Nesacaine | Y N |  | Gentamicin | Y N |  |
| Xylocaine | Y N |  | Cipro | Y N |  |
| Lidocaine | Y N |  | Erythromycin | Y N |  |
| Demerol | Y N |  | Advil | Y N |  |
| Codeine | Y N |  | Amoxicillin | Y N |  |
| Morphine | Y N |  | Ampicillin | Y N |  |
| Tylenol | Y N |  | Anaprox | Y N |  |
| Latex | Y N |  | Cytotec | Y N |  |
| Methotrexate | Y N |  | Remifentanil | Y N |  |
| Fentanyl | Y N |  | Versed | Y N |  |
| Other |  |  |  |  |  |

20. Do you have any environmental or food allergies? Y / N Unknown If yes, please list below

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

21. Are you allergic to anesthesia? Y / N Unknown

22. Do you, or anyone in your family, have malignant hyperthermia (severe over heating of the body generally

due to anesthetic)? Y / N Unknown

23. Have you, or any close relative, had a venous thrombosis (blood clot in leg, thigh, lung or pelvis)? Y / N

Unknown

24. Please list ANY medications, remedies you take on a daily/regular basis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

25. Do you have benefits for prescription drugs? Y / N

26. Do you smoke? Y / N

27. Do you use recreational drugs on a regular basis or have you been heavily dependent in the past? Y / N

If yes, please circle: Speed – Cocaine – Crack, Marijuana – Ecstasy – Mescaline – Crystal Meth – LSD

Methadone – Heroin – Morphine – Alcohol – Other.

Have you used any in the last 24 hours? Y / N If yes, what \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_how much\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

28. What method of birth control were you using when you became pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

29. What method of birth control would you like to use in the future? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth control requested\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rx Sample / Quick start

1. Whose decision is it for you to have this abortion? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. What would be helpful for you today?

\_\_\_ Having the procedure explained to me.

\_\_\_­ Getting birth control information.

\_\_\_ Being able to talk about my feelings with someone.

\_\_\_ Having my support person with me during the abortion.

\_\_\_ Does your support person want to speak with a counselor.

\_\_\_ Getting more information about fetal development.

\_\_\_ Having something to remember the pregnancy by.

\_\_\_ Talking about spiritual concerns and /or getting ideas about rituals or ceremonies.

\_\_\_ Referral for counseling.

\_\_\_ Do you want a counselor to phone you to follow up on your appointment.

\_\_\_ Viewing the fetal tissue and remains after the procedure.

\_\_\_ Taking the fetal tissue and remains after the abortion.

\_\_\_ I don't want to know about anything today.

We know that violence against women is a problem for many and can directly affect overall and reproductive health. Violence can take many forms; physical, emotional, sexual, financial, psychological, spiritual/religious, or neglect. It can also take the form of threatening to hurt you or someone you love.

3. Are you experiencing violence now or within the last 3 months prior to becoming pregnant? Y / N

4. Do you have any other concerns today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I last ate at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date/time) I last drank at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date/time)

**I HEREBY DECLARE THAT I FILLED OUT THIS FORM TO THE BEST OF MY ABILITY**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_