

# WOMAN'S HEALTH OPTIONS

## IDENTIFICATION FORM/ FOR PROCEDURE

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

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

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

Address: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City/Town) (Province/Country) (Postal Code)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Day Month Year

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

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

E-MailAddress \_\_\_\_\_

What is your first language? \_\_\_\_\_ Driver's Name/Phone # \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
(Name) (Phone Number)

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### 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 CMXV\_\_\_\_ 03.04A/V25.9 CMXC30 87.0A/635 81.8/V25.1 13.59A/626.8

03.08A/V25.0 79.29E/622.8 (Biopsy) 79.29E/622.7 (Polyp)

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. How many previous pregnancies have you had? \_\_\_\_\_.
4. 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 \_\_\_\_\_
5. How many vaginal deliveries have you had? \_\_\_\_\_
6. Have you had any previous cesarean sections? Y / N If yes, why \_\_\_\_\_
7. Have you ever had a miscarriage? Y / N If yes, how many \_\_\_\_\_
8. Have you ever had an ectopic pregnancy (tubal pregnancy)? \_\_\_\_\_
9. Have you ever had an abortion before? Y / N If yes, where and when \_\_\_\_\_
10. 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 When \_\_\_\_\_  
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
11. 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  
Would you like a test for HIV 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.**
12. Have you ever been admitted to a hospital before? Y / N If yes, what for \_\_\_\_\_
13. Have you ever had surgery on your Uterus, Fallopian Tubes or Cervix? Y / N  
If yes, what type of surgery? \_\_\_\_\_
14. 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 \_\_\_\_\_
15. Have you experienced any of the following (please circle)? **None** – Depression – Anxiety / Panic Attacks – Bi-Polar  
FASD – ADHD /ADD – Post Partum Depression – Schizophrenia / Borderline Personality Disorder – Anorexia / Bulimia –  
PTSD

16. 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	Remifentanyl	Y N
Fentanyl	Y N	Versed	Y N
Other			

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

\_\_\_\_\_

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

19. Do you, or anyone in your family, have malignant hyperthermia (severe over heating of the body generally due to anesthetic)? Y / N Unknown

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

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

22. Do you have benefits for prescription drugs? Y / N Treaty Benefits \_\_\_\_\_ Alberta Government \_\_\_\_\_ Other \_\_\_\_\_

23. Do you smoke? Y / N

24. 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 \_\_\_\_\_

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

26. 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. Please check items you would like to discuss with the counsellor.

\_\_\_ 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 ultrasound / procedure / counselling/ recovery.

\_\_\_ Getting more information about fetal development. (multiples/twin, gestational age)

\_\_\_ Having something to remember the pregnancy by (ultrasound picture/ other)

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

\_\_\_ Counselling resources.

\_\_\_ Do you want a counsellor 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.

We know that violence against women is a problem for many and can directly affect reproductive and overall 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? \_\_\_\_\_

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

5. Were you approached by protesters today? Y / N Would you complete an incident report? Y / N

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: \_\_\_\_\_