WOMAN'S HEALTH OPTIONS

IDENTIFICATION FORM / FOR PROCEDURE

Date: _____ Time: _____

Last Name: _____ First Name: _____

Preferred Name: _____ Pronouns (e.g.: she/her, he/him, they/them): _____

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)

****

FOR OFFICE USE ONLY

File No: _____

Fee: _____

Paid: _____

Balance: _____

Receipt No. _____

Birth Control:

Fee: _____

Receipt No. _____

Depo Evra Nuvaring IUD Nexplanon 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 (IUD Insert) 11.71A/V25.1 (IUD Removal) 13.59A/626.8

03.08A/V25.0 79.29E/622.8 (Biopsy) 79.29E/622.7 (Polyp) 98.01A/V25.8 : 03.03A/V26.4 (Nexplanon Insert) 98.04C/V25.4 : 03.04a/V25.9 (Nexplanon Removal)

Date appointment booked: _____

Revised 09/21

MEDICAL HISTORY

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

2. How many previous pregnancies have you had? _____.

3. 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_____

4. How many vaginal deliveries have you had? _____

5. Have you had any previous cesarean sections? Y / N If yes, why _____

6. Have you ever had a miscarriage? Y / N If yes, how many _____

7. Have you ever had an ectopic pregnancy (tubal pregnancy)? _____

8. Have you ever had an abortion before? Y / N If yes, where and when _____

9. 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

10. 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.

11. Have you ever been admitted to a hospital before? Y / N If yes, what for_____

12. Have you ever had surgery on your Uterus, Fallopian Tubes or Cervix? Y / N
    If yes, what type of surgery? _____

13. 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_____

14. 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

15. 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					

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

_____

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

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

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

20.. Please list ANY medications, remedies you take on a daily/regular basis: _____

21. Do you have benefits for prescription drugs? Y / N Treaty Benefits _____ Alberta Government ____ Other ____

22. Do you smoke? Y / N

23. 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_____

24. What method of birth control were you using when you became pregnant? _____

25. 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.

___ 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 ideas about rituals or ceremonies.

___ Counselling resources / coping information.

___ Being able to smudge before the procedure.

___ Including tobacco with the fetal tissue.

___ 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: _____