Date: _____

Women's Center

Orlando Abortion Clinic
1103 Lucerne Terrace
Orlando, FL 32806
Ph: (407) 245-7999
Toll Free: (877) 692-2273

EPOC Abortion Clinic
609 Virginia Drive
Orlando, FL 32803
Ph: (407) 898-2046
Toll Free: (877) 376-2227

Ocala Abortion Clinic
108 NW Pine Avenue
Ocala, FL 34475
Ph: (352) 401-9288
Toll Free: (877) 622-5234

Tampa Abortion Clinic
502 South Magnolia Ave
Tampa, FL 33606
Ph: (813) 258-5995
Toll Free: (877) 966-3672

Ft Lauderdale Abortion Clinic
2001 W. Oakland Pk Blvd
Ft. Lauderdale, FL 33311
Ph: (954) 733-0121
Toll Free: (877) 966-3673

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name *(Last, First, M.I.):* _____ **DOB:** ___/___/___

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Previous or referring doctor: _____ **Date of last exam:** ___/___/___ **Reason for Visit:** _____

REPRODUCTIVE HISTORY

MENSTRUAL

Age Menarche: **Cycle Interval:** (days) **Menses Duration:** (days) **Flow:** Heavy Moderate Light

LMP: _____

Certainty of LMP Date: Sure/Unsure

Office Pregnancy Test: Yes/No
Home Pregnancy Test: Yes/No

Breakthrough Bleeding: Yes/No
Number of Pads/Tampons: ___/per day

Method of Birth Control
☐ Condoms ☐ IUD ☐ OCP's ☐ Depo Provera ☐ Diaphragm ☐ Other

Menopause Status: Premenopausal/Peri menopausal/Post menopausal
Age Menopause:
On HRT? Yes/No **Medication name:**

Date of Last Pap smear: / / **Any Abnormal?** Yes/No **Date of Last Mammogram:** / / **Any Abnormal?** Yes/No

PREGNANCY SUMMARY

Total Pregnancies	Full Term	Premature	Elective Abortions	Miscarriages	Ectopic Pregnancies	Multiple Births	Total Living

PREGNANCY DETAILS

Date	Weeks	Hrs in Labor	Weight	Sex	Type	Anesthesia (epidural/IV/General Local/None)	Preterm Labor	Complications (Vacuum, forceps, VBAC, etc.)	Hospital/ MD
				M/F	Vag/CS		Yes/No		
				M/F	Vag/CS		Yes/No		
				M/F	Vag/CS		Yes/No		
				M/F	Vag/CS		Yes/No		
				M/F	Vag/CS		Yes/No		
				M/F	Vag/CS		Yes/No		
				M/F	Vag/CS		Yes/No		

MEDICATION LIST

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Dose and Frequency	Reason for Taking/Prescriber's Name

Women's Center — Health History Questionnaire

REVIEW OF SYSTEMS

GENERAL

	YES	NO	
1.	☐	☐	Eating disorder
2.	☐	☐	Frequent colds/flu, etc
3.	☐	☐	Chronic fatigue
4.	☐	☐	**Cancer**
5.	☐	☐	My health is good

SKIN

	YES	NO	
6.	☐	☐	Acne/skin problems
7.	☐	☐	Chronic rash, itching

EYES

	YES	NO	
8.	☐	☐	Eye problems/visual problems
9.	☐	☐	Do you wear glasses/contacts?

EAR, NOSE, MOUTH

	YES	NO	
10.	☐	☐	Hearing problems
11.	☐	☐	Teeth/gum problems
12.	☐	☐	Frequent nosebleeds
13.	☐	☐	Frequent sore throats

RESPIRATORY

	YES	NO	
14.	☐	☐	Asthma/Lung disease/TB
15.	☐	☐	Persistent shortness of breath

CARDIOVASCULAR

	YES	NO	
16.	☐	☐	**Heart disease/Murmur/Stroke**
17.	☐	☐	**High blood pressure**
18.	☐	☐	**High cholesterol/Triglycerides**
19.	☐	☐	**Thrombophlebitis/Blood clots in veins/lungs**
20.	☐	☐	**Lupus Erythematosis**

GASTROINTESTINAL

	YES	NO	
21.	☐	☐	Stomach/Bowel problems
22.	☐	☐	**Liver disease/Hepatitis**
23.	☐	☐	Gall bladder disease

GENITOURINARY

	YES	NO	
24.	☐	☐	Bladder/kidney problems
25.	☐	☐	Problems of infection with uterus/ tubes/ ovaries
26.	☐	☐	Recurrent vaginal infection
27.	☐	☐	Chlamydia
	☐	☐	Gonorrhea
	☐	☐	Herpes
	☐	☐	Syphillis
	☐	☐	Genital Warts
	☐	☐	HIV
28.	☐	☐	**Breast Lump/Tumor/Surgery**
29.	☐	☐	**Abnormal Pap Smear**

NEUROLOGIC

	YES	NO	
30.	☐	☐	**Stroke**
31.	☐	☐	**Migraine (diagnosis by MD)**
32.	☐	☐	**Seizures/Epilepsy**

HEMTAOLOGIC

	YES	NO	
33.	☐	☐	Anemia
34.	☐	☐	**Blood disorder/transfusion**

MUSC ULOSKE LETAL

	YES	NO	
35.	☐	☐	Arthritis
36.	☐	☐	Broken Bones/Fractures

PSYCHOLOGY

	YES	NO	
37.	☐	☐	
38.	☐	☐	**Depression/Mood Swings**
39.	☐	☐	Severe Anxiety
40.	☐	☐	**Under care of Psychiatrist/ Psychologist**

ENDOCRINE

	YES	NO	
41.	☐	☐	Thyroid disease
42.	☐	☐	**Diabetes Hypoglycemia**
43.	☐	☐	Persistent swollen glands
44.	☐	☐	Pituitary Tumor

PAST MEDICAL HISTORY:

45. Are you now, or have you been, under a doctor's care for a serious illness or condition? ☐ **YES** ☐ **NO**

46. Do you have any drug allergies? ☐ **YES** ☐ **NO** If yes, what? _____
Local anesthesia? ☐ **YES** ☐ **NO** Are you allergic to latex? ☐ **YES** ☐ **NO** Betadine? ☐ **YES** ☐ **NO**

47. Have you had childhood immunizations? ☐ **YES** ☐ **NO**

48. Food Allergies? ☐ **YES** ☐ **NO**

49. Have you been immunized for Hepatitis B? ☐ **YES** ☐ **NO**

50. Environmental Allergies? ☐ **YES** ☐ **NO**

51. Have you been immunized for Rubella? ☐ **YES** ☐ **NO**

52. Other Allergies? ☐ **YES** ☐ **NO**

ALLERGY LIST

ALLERGY NAME	REACTION
Drug Allergies:	
Food Allergies:	
Environmental Allergies:	
Other Allergies:	

53. Please list any drugs you are taking now, including over-the-counter medications, herbal medications, and vitamins. _____

54. Is this your first pelvic exam ☐ **YES** ☐ **NO**

55. **Date of last pelvic exam** _____

FOR CLINICIAN / RN USE ONLY

Women's Center — Health History Questionnaire

HISTORY REGARDING MOTHER, FATHER, SISTER OR BROTHER:

YES	NO	
☐	☐	Diabetes Insulin dependent? ☐ YES ☐ NO
☐	☐	Cancer, especially breast, kidney, ovarian or colon
☐	☐	High levels of cholesterol or fat in blood
☐	☐	**Heart attack, stroke, blood clots, high blood pressure**
☐	☐	Broken bones after age 35, or osteoporosis
☐	☐	Adopted, unknown family history
☐	☐	Did your mother take DES during her pregnancy with you?

FOR CLINICIAN / RN USE ONLY

SOCIAL/SEXUAL RISK HISTORY

YES	NO	
☐	☐	**Do you smoke? If yes, how many cigarettes a day? _____ How many years? _____ Packs per day? _____**
☐	☐	Do you use alcohol? If yes, how often/how much? _____
☐	☐	Do you or your partners use street or IV (injectable) drugs? Explain _____
☐	☐	Do you or your partners share needles of any kind?
☐	☐	Have you ever had or would you like help now with an alcohol or drug abuse problem?
☐	☐	Would you like to discuss problems related to a rape or emotional/physical/sexual abuse?
☐	☐	Are you now or have you ever been in a relationship where you have been physically hurt or threatened?
☐	☐	History of substance abuse? Explain _____

Your answers to the following questions will help us assess your risk for cervical cancer and sexually transmitted infections (STIs).
Age at first intercourse: _____

YES	NO	
☐	☐	Are you sexually active now? Check all that apply: ☐ Vaginal ☐ Anal ☐ Oral ☐ Other
☐	☐	Have **you had more than one or a new sexual partner in the past year?** Are your partners: ☐ Male ☐ Female ☐ Both
☐	☐	Do you take precautions against sexually transmitted infections?
☐	☐	**Do you feel that any of your partners have put you at risk for sexually transmitted infections or HIV?**
☐	☐	Do you have any other questions or concerns about sex that you would like to discuss during this visit?

REPRODUCTIVE HISTORY

Age at first menstrual period:_____

YES	NO	
☐	☐	Heavy periods / cramps
☐	☐	Bleeding between periods
☐	☐	**Was your last menstrual period normal?**

HAVE YOU EVER HAD:

YES	NO	
☐	☐	**Bleeding after intercourse**
☐	☐	**Pain with intercourse**

DO YOU CURRENTLY HAVE:

YES	NO	
☐	☐	**Lower abdominal pain**
☐	☐	**Abnormal vaginal discharge**

IF YOU HAVE EVER BEEN PREGNANT, PLEASE ANSWER THE FOLLOWING QUESTIONS

____ Age at first pregnancy
____ Total number of pregnancies
____ Number of live births
____ Date of last abortion
____ Number of abortions
____ Date of last delivery
____ Number of still births
____ Number of cesarean births (C-sections)

Did you have any complications during your pregnancies? ☐ **YES** ☐ **NO** Any children with genetic disorders (birth defects)? ☐ **YES** ☐ **NO**
Are you Currently Breastfeeding? ☐ **YES** ☐ **NO**

CONTRACEPTIVE HISTORY

Check all birth control methods you have used: ☐ Pill ☐ DEPO ☐ Norplant ☐ IUD ☐ Vaginal Ring ☐ Patch ☐ Diaphragm ☐ Sponge ☐ Foam/Suppository/Film ☐ Natural Family Planning (Rhythm) ☐ Withdrawal ☐ Condoms ☐ Sterilization Other_____

YES	NO	
☐	☐	Do you or your partner use birth control now? If yes, what method(s) do you use? _____
☐	☐	How long have you used this method? _____
☐	☐	Have you had problems with this or any birth control method?
☐	☐	Do you plan to get pregnant in the next year?
☐	☐	Do you want a birth control method today? If yes, what method?_____
☐	☐	Would you like to know about Emergency Contraception (Morning After Pill, Day After Pill, Plan B)

IF YOU ARE UNDER 18 YEARS OF AGE:

Are your parents aware of your visit to the Women's Center? ☐ YES ☐ NO
Do you talk to your parents about sexuality issues? ☐ YES ☐ NO

To the best of my knowledge this information is complete and correct.

_____ **Patient Signature** _____ Date _____ Clinician/RN Signature _____ Date

Date: _____

Women's Center — Health History Questionnaire

PAST MEDICAL HISTORY (Obstetrical, Gynecologic, Breast, Cardiovascular, Neurologic, Hematology, Digestive, Endocrine, Dermatology, Urology, Psychiatry)		
Diagnosis/Year	Details	Treatment/Follow-up

PAST SURGICAL HISTORY (Obstetrical, Gynecologic, Breast, Cardiovascular, Neurologic, Hematology, Digestive, Endocrine, Dermatology, Urology, Psychiatry)		
Diagnosis/Year	Details	Procedure/Treatment/Follow-up

Date: _____

Women's Center **Health History Questionnaire**

Patient Information

Last Name First Name Middle Name

Email Address

Home Address (number and street) Apt# City State Zip Code

Mailing Address if Different

Cell Phone Number Home Phone Number Work Phone Number

Date of Birth (Month, Day, Year) Occupation

Social Security Number

Employer's Name

Employer's Address (city, state, and zip code)

Employer's Phone Number(s)

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Spouse's Full Name

Spouse's Employer & Address Spouse's SS# Employer's Phone No.

Name of Person to Contact in Case of Emergency

Emergency Contact's Complete Address and Phone Number

Name of Nearest Relative Not Living with You

Nearest Relative's Complete Address and Phone Number

Referred By Gynecologist City

Insurance Information

Name of Insurance Company

Insurance Company's Complete Address (city, state, zip code)

Insurance Company's Phone Number

Insured's name (If other then yourself) Relationship to Insured Insured's DOB

Insured's I.D. # Group #

GENERAL ADMINISTRATIVE AND FINANCIAL AGREEMENT

The doctors and staff at The Woman's Center would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible. The following is our administrative and financial policies.

I agree and understand the following general administrative policies:

- It is my responsibility to inform The Woman's Center of any address or telephone number changes.
- My account is to be kept current-accordingly, all self-pay or insurance co-payments, co-insurances and deductibles will be collected at the time of service payable by cash, check, Visa, MasterCard or American Express.
- A returned check will result in a $25.00 service charge ***and*** all future payments being required in the form of cash, credit or debit card.
- I will only be sent a statement if my balance exceeds $5.00 and I will only receive a refund if the credit amount is over $10.00. I understand that refunds will be issued within 2 weeks from the date requested provided there are no insurance pending claims.
- There is a $35.00 charge for the completion of paperwork (ex. Disability, FMLA, etc.).
- Any unpaid balances older than 30 days may be subject to 1.5% interest per month.
- If my account is turned over to a collection agency, I will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of my outstanding balance, court costs and attorney fees.

If I have health insurance coverage:

We will submit your claims, however ***we must emphasize that as medical providers, our relationship is with you, not your insurance company***. Although we attempt to verify your *OB/GYN* benefits with your insurance company, please be advised that this is only an estimate of your coverage based on the information given to us at the time of the inquiry.

If I have health insurance coverage I agree and understand the following:

- It is my responsibility to inform The Woman's Center of any changes to my insurance policy so that my coverage can be re-verified prior to my appointment.
- I understand that if my insurance policy requires a referral from my primary care physician, it is my responsibility to have that faxed to The Woman's Center prior to my appointment
- I understand that not all services provided to me will be covered by my insurance plan.
- It is my responsibility to be aware of what service(s) is being provided by The Woman's Center and if it is a covered benefit under my insurance plan.
- I am responsible for any non-covered charges not payable by my insurance plan.
- I understand that The Woman's Center will file my insurance claims as a courtesy. My charges are always my responsibility.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. *We are here to help you.*

I have read and understand the above administrative and financial policies and agree to meet all financial obligations.

Patient Name (please print)	Patient Signature	Date
Responsible Party if other than patient (please print)	Responsible Party Signature	Date

NOTICE of HEALTH INFORMATION PRIVACY PRACTICES

As required by the Privacy Regulations Created as a Result of the
Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU AS A PATIENT OF THIS PRACTICE, MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

This practice is committed to treating and using protected health information about you responsibly. This **Notice of Health Information Practices** describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 1, 2003 and applies to all protected health information as defined by federal and state regulations.

Understanding Your Health Record/Information

Each time you visit our office a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing, with your authorization,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of this practice, the information belongs to you. You have the right to:

- Obtain a paper copy of this "Notice of Information Privacy Practices" upon request,

- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

We are required to:
- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the changes in our reception area. At your request and expense, we will provide a revised "Notice of Patient Privacy Practices" to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions, would like additional information or wish to report a problem, please contact the practice's Privacy Officer so we help you. We will take all reasonable steps to see that your concerns are addressed.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. To file a complaint with our practice, contact The Women's Center, Attn: Privacy Officer, at 609 Virginia Drive, Orlando, FL 32803. You cannot be penalized for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your doctor will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates:

For example: There are some services provided in our organization through contacts with business associates. When these services are contracted, we may disclose your health

information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. This information will be de-identified.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Abuse and Domestic Violence: As provided by federal and state law, we may, at our professional discretion, disclose to proper federal or state authorities healthcare information related to possible or known abuse or domestic violence. As also provided by federal and state law, we may refuse to disclose healthcare information to individuals, including legal parents guardians, custodians, etc., when such disclosure may be possibly be detrimental to the physical or mental healthcare or well being of the patient.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Notice of Privacy Policies Revision, 3/15/03

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have received a copy of The Women's Center Notice of
Patient Name
Privacy Practices.

_____ _____
Signature of Patient Date

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as a part of my healthcare, this practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care or treatment.

I understand that this information serves as:

A basis for planning my care and treatment
A means of communication among the health professionals who contribute to my care, i.e., consultations and referrals
A source of information for applying my diagnosis and treatment information to my bill for payment purposes
A survey for routine healthcare operations, such as assessing quality and reviewing the competence of staff

I have been provided the opportunity to review the *"Patient Privacy Practices"* that provides a more complete description of information, uses and disclosures. I understand that I have the following rights:

The right to review the ***"Patient Privacy Practices"*** prior to acknowledging this consent
The right to restrict or revoke the use or disclosure of my health information for purposes other than treatment or payment
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

Restrictions:

I request the following restrictions to the use or disclosure of my health information:

_____

_____

If there is anyone you do not want us to discuss your healthcare information with, please list their names and relationship below:

_____

_____

Messages or Appointment Reminders:

If you do not want us to leave a message on your answering machine or with someone at your home reminding you of an appointment, which may also include non-sensitive healthcare information, please check the box below:

Do not leave a message on my answering machine or with anyone at my home [ ]

I understand that as a part of my treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers, labs, and/or other individuals or agencies as permitted or required by state or federal law.

I fully understand the information provided by this consent.

_____	_____	_____
Signature	Printed name of person signing	Date

*If other than patient is signing, are you the parent, legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations. Yes [ ] No [ ]

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[ ] Patient refused to sign the consent form.
[ ] Reason for patient refusal to sign_____
[ ] Restrictions were added by the patient (see restrictions listed above)
[ ] "Consent form" received and reviewed by_____on (date)_____

BIRTH CONTROL SCREENING FORM

Name:_____ Date:_____

In addition to the medical history questionnaire you have been asked to complete, we would like you to take a moment to answer the questions below if you are considering any method of birth control. This will enable us to make a more complete evaluation of your health and your suitability for a birth control method. During counseling, please feel free to elaborate on any health concerns you may have and discuss questions with the counselor.

Have you ever had:

Clots in legs, lungs, or elsewhere?	_____Yes _____No
A stroke, heart attack or chest pain?	_____Yes _____No
Known or suspected cancer of the breast or sex organs?	_____Yes _____No
Severe liver disease?	_____Yes _____No
Irregular or scanty periods before starting to take the pill?	_____Yes _____No
Breast nodules, fibrocystic disease of the breast or abnormal mammogram?	_____Yes _____No
Diabetes?	_____Yes _____No
High blood pressure?	_____Yes _____No
High cholesterol?	_____Yes _____No
Migraine headaches?	_____Yes _____No
Heart or Kidney disease?	_____Yes _____No
Epilepsy/Seizures?	_____Yes _____No
Mental depression?	_____Yes _____No
Fibroid tumors of the uterus?	_____Yes _____No
Gallbladder disease?	_____Yes _____No
Asthma?	_____Yes _____No
Thyroid abnormalities?	_____Yes _____No
Sickle cell disease trait?	_____Yes _____No

Do you smoke cigarettes? _____Yes _____No

How many? _____ For how many years? _____

Is there a history of breast cancer in you family? _____Yes _____No

Do you now have:

Unusual bleeding that has not been diagnosed?	_____Yes _____No
Known or suspected pregnancy?	_____Yes _____No

Signature of Patient:_____

Thank you for choosing Women's Center Clinic for your medical needs. We will do our very best to provide you with confidential, courteous and professional care.

How do you feel about having an abortion? (Circle as many answers that apply)

Confused	Angry	Sick	Sad	Guilty	Don't want to do it
Scared	Okay	Fine	Good	Best thing	Forced into it
Secure	Positive	Wise	Don't care	Mixed feelings	
Certain	Bad	Necessary	Don't know	Other: _____	

Why are you having an abortion? (Circle as many answers that apply)

I'm too young I'm too old I can't afford it Health Not Married
I'm having legal problems I do not want any (more) children
I'm not prepared to have a child at this time My partner & I ended our relationship
My relationship with the man involved is not stable Other:_____

What is the man's response to this decision? (Circle answer)

He is being: Supportive Unpleasant Abusive

What are your main concerns about the abortion today? (Circle answers)

Pain Fear of needles That someone will find out That I'll have complications
Bleeding Vomiting/Nausea That it won't be complete That I'll be punished
That I'll be too far along That I'll be too early That I'll regret the decision
Other: _____

Have you talked with anyone about this decision? No_____ Yes (whom)_____
Were they supportive? No _____ Yes_____

Please help us to help others by indicating below how you became aware of our services.
Please check one:

_____Prior Patient _____Friend _____Newspaper Article _____Radio
_____Television News _____The picketers _____Newspaper _____Counselor
_____General Knowledge _____Sign Outside _____Planned Parenthood
_____Health Department _____Physician: Dr._____
_____Phone Book (which city?) _____

Other referral source not listed above: _____

Did you call other abortion providers before choosing Women's Center Clinic? Yes____ No____

Why did you choose Women's Center Clinic for your care at this time?

_____Convenient location _____Good Reputation _____Pleased with prior care
_____Friend Recommendation _____People were understanding and informative on the Phone
_____Other:_____

Name:_____ Date:_____