

Planned Parenthood of Indiana  
ABORTION HISTORY FORM

Patient name \_\_\_\_\_ Patient number \_\_\_\_\_ Birthdate \_\_\_\_\_ Date \_\_\_\_\_

Have you ever had an abortion at a Planned Parenthood clinic? \_\_\_\_\_ If so, what year \_\_\_\_\_ and at which location \_\_\_\_\_? If yes, was it medical or surgical? \_\_\_\_\_?

Please fill out the following questions:

**Pregnancy history:**

Date of last pregnancy (**not** including this one) \_\_\_\_\_

Number of total pregnancies (including this one) \_\_\_\_\_

Are you RH negative? \_\_\_\_\_ (had a shot of Rhogam after a pregnancy)

Number of live births \_\_\_\_\_ Dates \_\_\_\_\_ Number of abortions \_\_\_\_\_ Dates \_\_\_\_\_

Number of miscarriages \_\_\_\_\_ Dates \_\_\_\_\_ Number of stillbirths \_\_\_\_\_ Dates \_\_\_\_\_

Have you had a placenta previa? \_\_\_\_\_ Dates \_\_\_\_\_ Have you had a cesarean section? \_\_\_\_\_ If yes, any problems? \_\_\_\_\_ Last normal menstrual period date \_\_\_\_\_

**Please circle yes or no about the following medical conditions:**

YES NO Have you ever had high blood pressure?

YES NO Do you have a problem with blood clotting or have you ever had a blood clot?

YES NO Have you ever had migraines that were diagnosed by a doctor?

YES NO Have you ever had a stroke or heart attack?

YES NO Do you have poorly controlled diabetes?

YES NO Are you anemic?

YES NO Do you have a history of asthma? Do you regularly use asthma medication? \_\_\_\_\_ If yes, did you bring your asthma medication? \_\_\_\_\_ Patient instructed to use medication prior to the procedure \_\_\_\_\_.

YES NO Do you have HIV/AIDS?

YES NO Do you have a poorly controlled seizure disorder?

YES NO Are you currently using street drugs or are abusing alcohol?

YES NO Are you taking any medications? Please list \_\_\_\_\_.

YES NO Do you have symptoms of a vaginal infection? (itching, discharge, sores)

YES NO Are you having uterine pain or pain with intercourse?

YES NO Are you allergic to medicines, latex, or antiseptic solutions? If yes, please list \_\_\_\_\_

YES NO Have you had any type of cancer? If yes, list \_\_\_\_\_

YES NO Do you smoke cigarettes? How many a day? \_\_\_\_\_

YES NO Would you like to look at your ultrasound picture?

YES NO If we find you have a multiple pregnancy (more than one fetus) would you like us to tell you?

What birth control method would you like to leave the clinic with today? \_\_\_\_\_

Have you had problems with birth control in the past? \_\_\_\_\_

Patient signature \_\_\_\_\_ date \_\_\_\_\_

Staff signature \_\_\_\_\_ date \_\_\_\_\_

Medical Abortion History Addendum

Patient name \_\_\_\_\_

DOB \_\_\_\_\_

Pt. # \_\_\_\_\_

- YES NO Do you have severe liver disease?
- YES NO Are you breastfeeding?
- YES NO Are you currently on long-term steroid (cortisone, prednisone, dexamethasone) medicine
- YES NO Do you have a known or suspected ectopic pregnancy or adnexal mass or molar pregnancy?
- YES NO Do you have chronic adrenal failure?
- YES NO Do you have an allergy to mifepristone, misoprostol, methotrexate or other prostaglandin? (Cytotech)
- YES NO Are you taking anticoagulants (blood thinners)?
- YES NO Do you have a hemorrhagic (bleeding) disorder, or inherited porphyries?
- YES NO Are you under a psychologist's care?
- YES NO Do you have poorly controlled inflammatory bowel disease?
- YES NO Do you have chronic cardiovascular (heart) disease?
- YES NO Do you have hypertension (high blood pressure)?
- YES NO Do you have respiratory (lung) disease? Do you use an asthma inhaler?
- YES NO Do you have renal (kidney) disease?
- YES NO Are you an insulin dependent diabetic?
- YES NO Are you severely anemic?
- YES NO Do you have an IUD in place?
- YES NO Do you have large uterine fibroids?
- YES NO Do you have a poorly controlled seizure disorder
- YES NO Are you able to readily access a telephone, emergency medical care, or transportation?

Patient signature \_\_\_\_\_ date \_\_\_\_\_

Staff signature \_\_\_\_\_ date \_\_\_\_\_