PATIENT RECORD

PERSONAL DATA

Name (LAST, FIRST, MIDDLE INITIAL): _____ Age: _____

What is your height?: _____ FEET _____ INCHES Weight?: _____ PDS Date of Birth: _____

Address (STREET) _____ Social Security : _____

City: _____ State: _____ Zip: _____ County: _____

Home Telephone: ( ) _____ Work Telephone: ( ) _____

Employer's Name: _____ Occupation: _____

Marital Status: _____

Birth Place: _____

Notify in case of Emergency:

Emergency Contact Name: _____

Relationship: _____ Telephone: ( ) _____

Are they aware you are having this procedure:? ☐ YES ☐ NO

If OPTIONS needs to contact you for MEDICAL REASONS, please indicate your preference:

BY TELEPHONE, number (IF DIFFERENT THAN ABOVE):

PHONE DAY ( ) _____ EVENING ( ) _____

BY LETTER, address (IF DIFFERENT THAN ABOVE) _____

Who Referred You To Options?

☐ Friend/Relative _____ ☐ Here Before (WHEN) _____

☐ Physician (NAME/CITY) _____ ☐ Family Planning (WHO) _____

☐ Yellow Pages (WHAT CITY) _____ ☐ Other _____

FOR OFFICE USE ONLY

INTAKE

LMP ..... Was it normal: ☐ YES ☐ NO

Last Food Intake ..... AM/PM

Bleeding/Spotting since LMP: .....

Notes: .....

.....

SPECIFIC PROBLEMS

Allergies: .....

Medications .....

Notes: .....

.....

.....

COUNSELOR: .....

Medical History (THIS INFORMATION WILL REMAIN CONFIDENTIAL)

1. Were you using birth control when you became pregnant? ☐ YES ☐ NO
   If yes, what type? _____
2. Have you ever had a pelvic (internal) exam before? ☐ YES ☐ NO
3. Do you bleed after sex? ☐ YES ☐ NO
4. History of twins? ☐ YES ☐ NO
5. Fibroid tumors? ☐ YES ☐ NO
6. How many days does your period last? _____
7. Do you have a menstrual period every 26-30 days? ☐ YES ☐ NO
8. Do you bleed between periods? ☐ YES ☐ NO
9. Do you have pain with sex? ☐ YES ☐ NO
10. Pelvic inflammatory disease? ☐ YES ☐ NO
11. Ovarian cysts? ☐ YES ☐ NO

ENTER NUMBER, AND DATE OF:

12. Previous Pregnancies: #: DATES: _____
13. Miscarriages: #: DATES: _____
14. Living Children: #: DATES: _____
15. Live births: #: DATES: _____
16. Abortions: #: DATES: _____
17. Tubal Pregnancies: #: DATES: _____

18. **INDICATE EACH TYPE OF BIRTH CONTROL YOU HAVE EVER USED:**

☐ None ☐ Pill ☐ Condoms ☐ Foam ☐ Rhythm ☐ Withdrawal ☐ Norplant ☐ IUD ☐ Diaphragm ☐ Depo-Provera ☐ Sterilization ☐ Other

19. **DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING?** *Circle if you are not sure*

NO	YES		NO	YES		NO	YES	
		Cold			Breast Cancer			Diabetes
		Chronic Cough			Other cancer (list below)			Gonorrhea
		Shortness of Breath			Migraine Headaches			Syphilis
		Asthma			Sickle Cell Anemia/Trait			Tested HIV Positive/AIDS
		Bronchitis			Hepatitis			Drug addictions
		Pneumonia			Depression			Thyroid Disease
		Emphysema			Stroke			Gastrointestinal Disease
		Tuberculosis			Heart Attack			Neurological Disease
		Lung Trouble			Anemia			Blood Clotting Problems
		Heart Murmur			Scarlet/Rheumatic Fever			Bleeding Tendencies
		Palpitation			Liver Disease			Surgery (list below)
		Irregular/Fast heartbeat			Jaundice			Blood Transfusion
		Chest Pains/Angina			Kidney Trouble			Do you smoke
		Low Blood Pressure			Chlamydia			Anesthesia Problems
		High Blood Pressure			Phlebitis			Trouble with Periods
		Pulmonary Embolism			Convulsions			Trouble/Bowel Movement
		Varicose Veins			Psyche Treatment			Trouble/Urinating
		Hypoglycemia			Epilepsy			Other (list below)
		Loss of Vision			Sexually Trans Diseases			

20. **IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:** _____

_____

ALLERGIES:

21. Are you allergic to any food? ☐ NO ☐ YES IF YES, what? _____
22. Allergy to any medication? ☐ NO ☐ YES IF YES, what? _____
23. Other allergy? ☐ NO ☐ YES IF YES, explain: _____

MEDICATIONS:

24. Do you take any medication or use any drugs on a regular basis? ☐ NO ☐ YES
    IF YES, what kind and for what reason? _____
25. Have you taken any medication or drugs of any kind today? ☐ NO ☐ YES
    IF YES, what kind and for what reason? _____

26. **INDICATE ☒ ALL MEDICATIONS YOU ARE CURRENTLY TAKING, OR HAVE EVER TAKEN, AND APPROXIMATE DATE:**

☐ Insulin (WHAT KIND): _____ DATES _____
☐ Blood Thinner/Coumadin: DATES _____
☐ Blood Pressure medicine: DATES _____
☐ Heart medicine: DATES _____
☐ Diabetic medicine: DATES _____
☐ Steroids, Cortisol, ACTH: DATES _____
☐ Sleeping pills: DATES _____
☐ Tranquilizers: DATES _____
☐ Sedatives: DATES _____
☐ Diuretics (water pills): DATES _____
☐ Anti-depressants: DATES _____
☐ Pain pills or shots: DATES _____

I CERTIFY THAT I HAVE FULLY AND COMPLETELY DISCLOSED MY MEDICAL HISTORY AND I UNDERSTAND THAT MY PHYSICIAN WILL RELY ON THIS DISCLOSURE AS COMPLETE.

_____ _____

Patient's / Guardian's Signature Date