FERTILITY CONTROL CLINIC

ESTABLISHED 1972

# MEDICAL HISTORY FOR MEDICAL ABORTION

Please complete the following medical history questionnaire. Our health care team, including your doctor, will review the completed form to assess your suitability for a medical abortion procedure.

| No | Medical History Details | | | Internal Use |
|---|---|---|---|---|
| 1 | **SURNAME** | | | |
| 2 | **GIVEN NAMES** | | | |
| 3 | **Date of Birth** | | | |
| 4 | Are you sure of your decision to have a medical abortion? | | Yes☐ **No☐** | |
| 5 | Is this your first pregnancy?<br>If **Yes**, go to **a** and **b** | | Yes☐ **No☐** | |
| | **a)** Are you breastfeeding now? | | **Yes☐** No☐ | |
| | **b)** Were there any complications? | | **Yes☐** No☐ | |
| 6 | Have you had any miscarriages?<br>If **No**, go to **7**.<br>If **Yes**, answer **c - e** | | **Yes☐** No☐ | |
| | **c)** How many miscarriages have you had? | | | |
| | **d)** Are you breastfeeding now? | | | |
| | **e)** Were there any complications? | | **Yes☐** No☐ | |
| 7 | Have you ever had an abortion before?<br>If **No**, go to **8**.<br>If **Yes**, answer **f - h** | | **Yes☐** No☐ | |
| | **f)** When and where was the last abortion? | | | |
| | **g)** What type of abortion did you have (*select*)? | **MEDICAL ABORTION** | **SURGICAL ABORTION** | |
| | **h)** Were there any complications? | | **Yes☐** No☐ | |
| 8 | Have you ever had an ectopic pregnancy?<br>If **Yes**, provide some details: | | **Yes☐** No☐ | |
| 9 | **i)** When was first day of your last period? | | | |
| | **j)** How often do you get a period *(select)*? | **28 days** | **>28 days** **<28 days** **Irregular** | |
| | **k)** How many days do you bleed *(select)*? | **< 5days** | **5-10 days** **>10 days** | |
| | **l)** How would you describe the amount of bleeding? | **Mild** | **Moderate** **Heavy** | |
| | **m)** How would you rate pain with periods *(select)?* | **None** **Mild** | **Moderate** **Heavy** | |

| No | Medical History Details | | Internal Use |
|---|---|---|---|
| 10 | Were you using contraception when you fell pregnant?<br>If **Yes**, answer **n -o** | **Yes**☐ No☐ | |
| | **n)** What contraception did you use? | | |
| | **o)** Is there any contraception that interests you and why? | | |
| 11 | Do you have or had any of the following medical problems **i - xv**? | | |
| | i. Asthma | **Yes**☐ No☐ | |
| | ii. Diabetes | **Yes**☐ No☐ | |
| | iii. Epilepsy | **Yes**☐ No☐ | |
| | iv. High blood pressure | **Yes**☐ No☐ | |
| | v. Heart problem | **Yes**☐ No☐ | |
| | vi. Heart murmur | **Yes**☐ No☐ | |
| | vii. Anaemia | **Yes**☐ No☐ | |
| | viii. Bleeding problem | **Yes**☐ No☐ | |
| | ix. Blood disorder | **Yes**☐ No☐ | |
| | x. Liver disorder | **Yes**☐ No☐ | |
| | xi. Severe diarrhea | **Yes**☐ No☐ | |
| | xii. Crohn's disease | **Yes**☐ No☐ | |
| | xiii. Sexually transmitted infection | **Yes**☐ No☐ | |
| | xiv. Adrenal gland problem | **Yes**☐ No☐ | |
| | xv. Other medical condition<br>If **Yes**, please specify: | **Yes**☐ No☐ | |
| 12 | Do you take any medications?<br>If **Yes**, please name: | **Yes**☐ No☐ | |
| 13 | Do you have any allergies?<br>If **Yes**, please explain: | **Yes**☐ No☐ | |
| 14 | Do you smoke cigarettes?<br>If **Yes**, how many? | **Yes**☐ No☐ | |
| 15 | Do you drink alcohol? **Yes** ☐ No☐<br>If **Yes**, how often *(select)*? **Every day** **Once a week** **Weekends** **Monthly** | | |
| 16 | Do you take any recreational drugs? **Yes** ☐ No☐<br>If **Yes**, how often *(select)*? **Every day** **Once a week** **Weekends** **Monthly**<br>And what type of drugs? | | |
| 17 | Are there any questions that you would like to ask the doctor about medical abortion? | | |