MT: C / P / S / V   Loc   MF   1st pelvic   Name Alert   Locker# _____   Other: ________________

Patient ID # _______________

Name ____

Appoint. Date ____________ Date of Birth _________ Age _____

Address ____________________________ County _____________

City ______________________ State _______ Zip _____________

Home Phone ________________S.S. # ______________________

Cell Phone or other number _______________________________

In Case of Emergency, notify: ______________________________

Address ____

Phone ____________________ Relationship _________________

Occupation: Employed ❑ Looking ❑ Unemployed ❑

Employer ____

Business Address ______________________________________

Business Phone ____

Education: (Specify only highest grade completed)

Elementary/Secondary (0-12) ___________________

College (1-4 or 5+) ___________________

Race/Ethnic Background:

African American ❑ Native American Indian ❑

Asian ❑ Caucasian ❑

Of Hispanic Origin? Yes ❑ No ❑ (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify if yes ______________________________________

Religion:

Religious Preference (specify) _____________________________

No Religious Preference ❑

Marital Status:

Single, never married ❑ Married ❑ Partnered ❑

Separated ❑ Divorced ❑ Widowed ❑

How did you find out about us? ____________________________

When was the first day of your last menstrual period?

(first day of bleeding) ______ / _______ / ______

How many days did that period last? _________ days

Was it a normal period? ❑ Yes ❑ No

Total number of pregnancies prior to current pregnancy: _____

Number of live births: ____ Number of children now living: ____

Previous vaginal delivery? ________________________________

Problems dilating? ____________________________________

Ever had a C-section? List what years: ______________________

Ever had a miscarriage? List what years: ____________________

Did the miscarriage require a D & C? ❑ Yes ❑ No

Ever have an abortion? List what years: _____________________

❑ Surgical Abortion ❑ Mifeprex (Abortion Pill)

Were you using birth control at time of this pregnancy? ❑ Yes ❑ No

If yes, what type was it?

Oral Pill ❑ I.U.D. ❑ Diaphragm ❑ Patch ❑

Cream and/or Foam ❑ Depo Provera ❑ Ring ❑

Condoms (Rubbers) ❑ Rhythm ❑ Withdrawal ❑

Other (specify) _______________________________________

Do you plan to use any method of birth control after procedure?

❑ Yes ❑ No

Have you ever used birth control pills? ❑ Yes ❑ No

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Do you smoke? ❑ Yes ❑ No How much? ________________

Have you ever used an I.U.D.? ❑ Yes ❑ No

Did you have any problems from any birth control you used?

❑ Yes ❑ No

If (yes) please explain problems:

Weight gain ❑ Bleeding between periods ❑

Heavier Periods ❑ Nausea ❑ Increased headaches ❑

Increased Irritation ❑ Increased depression ❑

Other (specify) ____

If you have ever had any of the following, check the appropriate box. (Check as many boxes as may apply)

	Yes	No
A) Infectious disease (ex: mono, hepatitis)	❑	❑
B) Reaction or allergy to medications/drugs/foods/latex?	❑	❑
If yes, list: ______________________________		
C) Previous surgery (ex: tonsillectomy)	❑	❑
D) Sexually transmitted infections (chlamydia, gc, HPV, HIV)	❑	❑
E) Diabetes	❑	❑
F) Bleeding tendencies	❑	❑
G) Heart problems (ex: murmur)	❑	❑
H) Neurological problems (ex: fainting or seizures)	❑	❑
I) Liver problems	❑	❑
J) Lung or breathing problems	❑	❑
K) Hearing problems	❑	❑
L) Intestinal problems	❑	❑
M) Kidney problems	❑	❑
N) Have you ever seen a counselor or a psychiatrist?	❑	❑
O) Previous hospitalization	❑	❑
P) High Blood Pressure	❑	❑
Blood Pressure medication	❑	❑
Q) Abnormal Pap Smear?	❑	❑
R) LEEP / Cone / Cryo procedure?	❑	❑
S) Any other significant medical problem?	❑	❑

If you have responded "Yes" to any of the above, please use the following space to explain:

____

____

____

List all medications and herbal supplements you are taking: ____

____

____

I hereby declare that I have read the foregoing and know the contents thereof and the same is true to the best of my knowledge. I acknowledge that the Knoxville Center for Reproductive Health, Inc. and its staff will rely upon the representations contained herein, and in the event that any of these representations is untrue in whole or in part, the Knoxville Center for Reproductive Health, Inc. is hereby absolved from any liability caused by its reliance on such untrue statements.

Date _____________ Patient ______________________________

I have discussed the contents of this questionnaire with this patient and she has acknowledged to me the accuracy of the statements made herein.

Date _____________ Counselor ____________________________

BC: FU: ❑ Call Counselor: