Fertility Control Clinic

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.

Medical History Details (page 1 of 3) Internal:

1. Surname: _____

2. Given names: _____

3. Date of birth: _____

4. Are you sure of your decision to have a medical abortion? YES or NO

5. Have you been pregnant before? YES or NO
If **NO, go to Question 9*
If **YES, answer the following (a-c):*

a) How many children do you have? _____

b) Did you have a normal delivery(ies)? YES or NO

c) Are you breastfeeding now? YES or NO

6. Have you had any miscarriages? YES or NO
If **NO, go to Question 7*
If **YES, answer the following (d-e):*

d) How many miscarriages have you had? _____

e) Were there any complications? YES or NO

7. Have you ever had an abortion before? YES or NO
If **NO, go to Question 8*
If **YES, answer the following (f-h):*

f) When & where was the last abortion? _____

g) What type of abortion did you have? MEDICAL ABORTION or SURGICAL ABORTION

h) Were there any complications? YES or NO

8. Have you ever had an ectopic pregnancy? YES or NO
If **YES, please provide some details:*

9. When was the first day of your last period? _____

10. Were you using contraception when you fell pregnant? YES or NO
If **YES, answer the following (i-j):*

i) What contraception did you use? _____

j) *Is there any contraception that interests you and why?* _____

11. Do you have / have you had any of the following medical problems?:

i) Asthma YES or NO

ii) Diabetes YES or NO

iii) Epilepsy YES or NO

iv) High Blood Pressure YES or NO

v) Heart Problem YES or NO

vi) Heart Murmur YES or NO

vii) Anaemia YES or NO

viii) Bleeding Problem YES or NO

ix) Blood Disorder YES or NO

x) Liver Disorder YES or NO

xi) Severe Diarrhoea YES or NO

xii) Crohn's Disease YES or NO

xiii) STI YES or NO

xiv) Adrenal Gland Problem YES or NO

xv) Other Medical Condition YES or NO

If **YES ('for other'), please specify:*

_____

_____

Internal:

12. Do you take any medications? YES or NO

If **YES, please name:* _____

13. Do you have any allergies? YES or NO

If **YES, please explain:* _____

14. Do you smoke cigarettes? YES or NO

If **YES, how many?* _____

15. Do you drink alcohol? YES or NO

If **YES, how often?* DAILY ONCE A WEEK WEEKENDS MONTHLY

16. Do you take any recreational drugs? YES or NO

If **YES, how often?* DAILY ONCE A WEEK WEEKENDS MONTHLY

**And what type of drugs?* _____

17. Are there any questions that you would like to ask the doctor about medical abortion?

_____

_____

_____

_____