



Clinic For Women
3607 West 16th Street Suite B-2
Indianapolis, IN 46222
317-955-2641

Chart # _____ Date _____

Pt. Name _____ Age _____ DOB _____

Address _____ City _____ ST _____ ZIP _____

Home Phone () _____ Work Phone () _____

Place of Employment

Work Address _____ City _____ ST _____ ZIP _____

Health Insurance Company _____

Policy # _____ Group # _____ SSN _____

In Case of Emergency, Contact _____ Relationship _____

Address _____ City _____ ST _____ ZIP _____

Home Phone () _____ Work () _____

Does your emergency contact know about the reason for your visit? Yes _____ No _____

**CLINIC FOR WOMEN
MEDICAL HISTORY**

Chart # _____ Date _____ Age _____ DOB _____

Pt. Name _____ Marital Status: S M D W

Education (enter highest grade completed): _____

Home Phone (____) _____ Work Phone (____) _____

Allergies to Medications? N Y If yes, list _____

Medications Currently Taking _____

Do you smoke? N Y How much? ____pk/day How many years? _____ I quit, date _____

Do you drink alcohol? N Y How many drinks per week? _____

Have you ever used IV drugs, cocaine or marijuana? N Y If yes, which drugs? _____

Have you ever experienced physical, sexual or emotional abuse? NY If yes, who knows about this? _____

Have you ever had surgery? N Y What kind? _____ When? _____

Name of your gynecologist or private physician _____

GYNECOLOGICAL HISTORY

First day of last period? _____ How many pregnancies before this one? _____

Was it: normal short spotty long heavy # of live births _____ # of c-sections _____

Are your periods usually: heavy moderate light # of abortions _____ # of ectopic preg _____

Are your cramps: mild moderate severe # of miscarriages ____ Your blood type _____

How often do your periods occur? _____ days List any problems with pregnancies _____

What birth control were you using when you got pregnant? _____

Have you used this birth control before? N Y

What birth control do you want today? _____

Date of last physical exam _____ Date of last pap test _____ Was it normal? N Y

Have you ever had any of the following? (Circle the correct response.)

Abnormal pap smear	N	Y	Gonorrhea or Chlamydia	N	Y
PID or Pelvic Inflammatory Disease	N	Y	Venereal Warts or Herpes	N	Y
Blood transfusions	N	Y	Blood dots in legs, lungs	N	Y
Heart Murmur/Mitral Valve Prolapse	N	Y	Serious illness	N	Y
Problems with contraception	N	Y	Major surgery	N	Y

Please explain all "yes" answers, including when it occurred _____

Have you or any of your family had any of the following? (Check only if the answer is "yes.")

	Self	Mother	Father		Self	Mother	Father
Heart disease/attack	?	?	?	Psychiatric treatment	?	?	?
High blood pressure	?	?	?	Drug/Alcohol Addiction treatment	?	?	?
Rheumatic Fever	?	?	?	Hepatitis/Liver Disease/Mono	?	?	?
Blood clots	?	?	?	Kidney problems	?	?	?
Varicose veins	?	?	?	Bladder problems	?	?	?
Fainting spells	?	?	?	Breast disease	?	?	?
Epilepsy/Convulsions/Seizures	?	?	?	Asthma	?	?	?
Migraine headaches	?	?	?	Respiratory problems	?	?	?
Stroke/Numbness	?	?	?	TB or lung problems	?	?	?
Diabetes/Sugar	?	?	?	Cancer: Genital	?	?	?
Thyroid disease	?	?	?	Breast	?	?	?
Adrenal disease	?	?	?	Other _____	?	?	?
Anemia	?	?	?	Fibroids/Cysts	?	?	?
Sickle Cell Anemia or Trait	?	?	?	Ovary/Fallopian Tube problems	?	?	?
Glaucoma	?	?	?	Infection of Ovary/Tube/Uterus	?	?	?
Other _____	?	?	?	Abnormal Vaginal Discharge	?	?	?

I understand that misrepresenting my medical history and current medical status could result in surgical and/or medical complications. By my signature I declare the above information to be truthful.

Signed _____ Date _____

Clinic For Women
Surgery Record

Pt. Name _____ Chart # _____

Age _____ Date _____

Counselor Records Counselor _____ Time In _____ am/pm

LMP _____ Weeks/Days _____ w/ _____ d SO here today _____

(circle one) SMOKER NON-SMOKER

Notes:

Procedure questions/discussion _____

Aftercare questions/discussion _____

Contraceptive request/discussion _____

RH type _____ Immune Globulin refusal? N Y Consent signed? N Y Time Out _____ am/pm

Ultrasound: _____ w/ _____ d Cytotec given? N Y Time given: _____ am/pm Hct: _____

Nursing Records _____

Oral Sedation

Valium 5mg/10mg Motrin 800ng Naproxen 550mg Time given: _____ am/pm Staff Signature _____

Physician Records

Examination: Uterine Position: Antiverted _____ Retroverted/flexed _____ Mid _____

Gestational Size _____ wks LMP Adnexa: Normal _____ Abnormal _____

Procedure: Anesthesia: Lidocaine 1% _____ Sodium Bicarbonate 8.4% _____ Total cc's _____

Application: Paracervical _____ Intracervical _____ Other _____

Dilation & Suction Curettage _____ Sharp Curette _____ Other _____

Curette/cannula size _____ mm Time Completed _____ am/pm

Physician Orders: _____

_____ Physician Signature _____

Tissue: _____ gm gross weight Chorionic Villi Y N Fetal Parts Y N FFM _____ mm

Ectopic Watch Begun Y N Unusual Findings _____

Staff Signature _____ Physician's Initials _____

Ultrasound Records

BPD _____ mm _____ weeks/days CRL _____ mm _____ weeks/days

Referral for 2nd trimester abortion: _____

Other referral: _____

Ultrasonographer's Signature _____

PATIENT CONSENT FORM FOR TERMINATION OF PREGNANCY
DO NOT SIGN UNLESS YOU FULLY UNDERSTAND THE FOLLOWING

1. I, _____ am ____ years of d. I request that an abortion, which is a surgical procedure to end my pregnancy, be performed on me by _____, a contract physician with Clinic For Women (CFW).

Physician's Name

INSTRUCTIONS TO PATIENT: Please put your initials in each parenthesis as you read, understand, and agree:

- () 2. I have made this decision to have an abortion because I do not want to have a baby at this time. I know my other choices are giving birth and adoption, but abortion is my personal choice. No one is forcing me to choose abortion, it is my decision.
- () 3. I have told all of my past and present medical history, including allergies, blood conditions, prior medicines and drugs taken, also any adverse reactions to anesthesia, medicines, or drugs. I understand that a full and complete disclosure of my medical history is important to help minimize the risks of complications which may occur with an abortion. I understand that the physician of CFW is relying on my information to be truthful and complete.
- () 4. The first day of my last normal period was _____, 200___. I have described in today's medical history any unusual characteristics of this period because I realize this information is important in determining how far into my pregnancy I am and whether an abortion can be done in an out patient clinic in Indiana. The physician's decision to proceed with the abortion is based on the above information as well as findings from examination and possible ultrasound.
- () 5. I give my consent to be given local anesthesia or pain medicine except _____, because I am allergic to it. I understand that local anesthesia does not eliminate all pain, and that in a small number of cases, patients could have a severe allergic reaction to a local anesthetic including shock, or even death.
- () 6. I give my consent to the taking of cultures, smears and other medical tests that the physician feels is appropriate or necessary. I understand that tissue and/or fetal parts will be removed during the abortion and I give my permission for them to be disposed of according to state law.
- () 7. I understand that there are risks of both major and minor complications which may occur with this, as with all surgical procedures. No guarantee has been made to me. These complications can include, but are not limited to, perforation of the uterus (putting a hole through the uterine muscle), hemorrhage (severe bleeding), retained tissue and/or infection, all of which could be severe enough to require surgery resulting in hysterectomy (removal of the uterus), and/or sterility (never being able to become pregnant again), or even death. If any of the above reactions or complications do occur, I further realize that I may need to be hospitalized which would be at my own expense. I realize that such complications can be caused by other medical conditions not related to the pregnancy termination procedure and/or by my failure to follow post-operative instructions, or by the treatment of the follow-up physician.
- () 8. Should I require hospitalization or medical treatment by a physician not affiliated with CFW for any reason related to this abortion, I now give my permission for the release of all medical records associated with such care. I understand that I am giving my permission prior to such care.
- () 9. If an unforeseen condition or complication arises during the abortion which in accordance with good medical practice calls for a different or additional treatment, I give the physician permission to do whatever in her/his professional judgment is necessary. Examples of such treatment are: the administration of IV fluids, the use of ultrasound during the abortion, repair/suturing of a cervical tear.
- () 10. I fully understand that there is no guarantee that this abortion will terminate my pregnancy. Therefore, it is very important that I have a post-abortion check-up within 4 weeks to be certain that I am no longer pregnant and that no other medical problem has occurred of which I may be unaware.

(Please continue on next page)

- () 11. I have had full opportunity to ask questions about my abortion and the risks and alternatives involved and am satisfied with the answers. I understand that any further questions I may have will be answered before I leave the clinic - I have only to ask them. I understand that it is my responsibility to bring to the attention of CFW any post-abortion problems I may encounter. The problems could include fever, heavy bleeding, severe cramping or pain, unusual or foul smelling discharge, or the absence of a normal period within six weeks of the procedure. I realize that, should any such problems arise, immediate treatment may be necessary to avoid more severe complications. I also realize that any questions I have after leaving the clinic today can be answered by calling CFW, since our telephone is answered 24 hours a day, seven days a week.
- () 12. I understand that following an abortion I may experience feelings of regret and/or depression - emotional distress. I have been told that resolution of my feelings prior to the abortion procedure is the best protection from emotional distress post-operatively. I have had an opportunity to fully discuss my feelings about this pregnancy and impending abortion and am comfortable with my decision to terminate this pregnancy. / wish to schedule additional time for discussion of emotions/feelings associated with this abortion before proceeding:
(please circle one) Yes No
- () 13. I am a minor who has gone through the Judicial Bypass procedure. I understand that it may still be necessary to contact my parent or legal guardian to get consent from that person in the event of an emergency or a complication that requires hospitalization.
- () 14. Any birth control methods I wished to know more about have been explained to me and I plan to use _____ . If I have chosen birth control pills, I understand that their possible side effects include severe headaches, leg cramps, blurred vision, blood clots, chest pains and stroke. I agree to report any and all side effects to CFW or to my own health care practitioner.
- () 15. I understand that serious problems after an abortion are rare and could be resolved right in the clinic without further cost to me. I also understand that if I do not contact CFW, but instead go to an emergency room or another doctor for care, CFW cannot be responsible for any costs or treatment that results.

I certify that I have read (or have had read to me) and fully understand the above consent form regarding my abortion, that the explanations therein referred to were made and that I completed all blanks or statements.

DO NOT SIGN UNTIL YOU HAVE COMPLETELY READ AND FULLY UNDERSTAND THE ABOVE.

PARENT _____ SIGNATURE _____

WITNESS _____ DATE _____ am/pm

=====

I give permission for release of my records from Clinic for Women to:

Name (Doctor or Clinic) _____

Address _____

DATE

SIGNATURE

HOW ARE YOU FEELING?

You will be speaking with a counselor during your visit. Answering these questions will help us to discuss what's most important to you.

1. If you have considered options other than abortion, what are they? _____

2. Was this a difficult ___ or an easy ___ decision?

3- Whose decision is it for you to have this abortion? _____
Have you discussed your decision with anyone? _____ If so, who?_

4. Name of father? _____

5. Does he know of your decision? _____

6. Does he support your decision? _____

7. What are your thoughts today about ending your pregnancy?

8. Please circle all the words that describe how you feel:

happy	guilty	numb	selfish
sad	confused	ashamed	unsure
angry	scared	resolved	conflicted
confident	relieved	trapped	nervous
others: _____			

9. Please check off the items below that concern you the most today.

<input type="checkbox"/> If I made the right decision.	<input type="checkbox"/> I believe abortion is wrong.
<input type="checkbox"/> I believe abortion is sinful	<input type="checkbox"/> I'm afraid I'll be judged.
<input type="checkbox"/> Someone is forcing or pushing me to do this.	<input type="checkbox"/> I wish someone else would make the decision.
<input type="checkbox"/> I don't really want an abortion.	<input type="checkbox"/> How I will feel emotionally after the abortion.
<input type="checkbox"/> How abortions are done.	<input type="checkbox"/> Whether abortions are safe.
<input type="checkbox"/> If the abortion will hurt.	<input type="checkbox"/> If I will be able to have children later.
<input type="checkbox"/> Fetal development; whether the fetus feels pain.	<input type="checkbox"/> I have lost respect for myself.

Other:

Thank you.

Patient's name: _____