Alamo Women's Clinic of Albuquerque
10151 Montgomery Blvd NE
Albuquerque, NM 87111

REQUEST FOR ULTRASOUND EXAMINATION

Date: _____

Patient Name: _____

Date of Birth: _____

I understand that a diagnostic ultrasound is a procedure that enables the clinician to view my pregnancy in order to determine the age of the fetus and to look at other structures in my uterus. This is done with an instrument that sends sound waves through the amniotic fluid (water bag).

I understand that this ultrasound is being done only to determine the age of the fetus and not abnormalities of my pregnancy, fetus, or reproductive tract. More extensive studies may be needed to diagnose specific conditions or abnormalities in the pregnancy. If more extensive studies are needed, I understand that I will be referred to a specialist for further testing. I also understand there are limitations to all imaging techniques.

While there is no evidence at present to prove negative effects of ultrasound on a developing fetus, I am aware there may be unrecognized risk with long term exposure in any procedure.

I have read and understand the above information.

I authorize the attending physician and/or trained medical staff from any liability arising out of or connected with this procedure and particularly with regard to any abnormalities of my pregnancy, fetus, or reproducing tract that have not been evaluated by this study.

I hereby request that the physician and/or trained medical staff authorized by the attending physician and/or Medical Director to perform an ultrasound screening on me for the sole purpose to determining the age of the fetus.

_____ _____
Signature of Patient Date

I witness the fact that the patient has read the above information and said that she has read and understands same.

_____ _____
Signature of Witness Date

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PATIENT INFORMATION

(Please print clearly)
All information **must** be correct and complete.

PATIENT NAME: _____
First Name Middle Initial Last Name
DATE OF BIRTH: _____ AGE: _____ SS#: _____
DRIVER'S LICENSE OR ID#: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
*PHONE: _____ May we leave a message? YES / NO *In the instance we may need to reach you.
COUNTY: _____ RACE: _____
MARITAL STATUS: ___M ___S ___D ___W SPOUSE'S NAME: _____
EMPLOYER'S NAME: _____ PHONE: _____
EMERGENCY CONTACT PERSON: _____
EMERGENCY CONTACT PHONE: _____RELATIONSHIP: _____

PAYMENT ARRANGEMENT: (READ CAREFULLY)
Payment is expected in full amount before services are rendered. ONLY CASH, VISA, MASTERCARD AND DISCOVER CARDS ACCEPTED.

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION:
I fully comprehend the privacy notice given to me by Alamo Women's Clinic of Albuquerque I understand I must complete a medical release form in order to receive copies of my medical records or in order to have any of my medical information released to any person or facility. There is a fee for the release of medical records. I authorize Alamo Women's Clinic of Albuquerque to contact and give information about my medical condition in the event of an emergency and/or to the emergency contact person listed above.

WE RESERVE THE RIGHT TO REFUSE SERVICES:

To any person requesting an abortion who does not have the appropriate identification, is unaccompanied by a driver on the day of the abortion procedure or on any day on which sedation is administered, is under the influence of alcohol, illegal drugs and / or prescription medication(s) which in any manner may alter the patient's ability to make an informed consent, or any abusive behavior.

The nursing staff has reviewed with me, in the event I need to seek medical attention after I have left the facility; I will contact the on-call nurse and proceed to the hospital closest to my residence.

Hospital: _____ Phone: _____

Patient Signature: _____ Date: _____

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Medical History Form

This questionnaire is part of your medical record and is used by staff to anticipate any problems you might relating to your appointment. This record is strictly confidential. Please do not leave anything blank.

Patient Information:

Name _____ Date of Birth _____Age _____

Menstrual History:

What was the first day of your last period, and was it normal? _____

Has pregnancy been confirmed by: ☐Urine test at home? ☐Urine test at a clinic? ☐Blood test at a clinic? ☐None

Pregnancy History:

Total number of times you have been pregnant **excluding** today (if applicable)? _____

Number of Vaginal Deliveries _____ Number of C-Sections _____ Number of Miscarriages _____

Number of Abortions _____ Number of Ectopic Pregnancies _____ Number of Molar Pregnancies_____

Complications Related to any _____

☐ Currently breastfeeding ☐Rh negative / RhoGAM injection in previous pregnancy Age of children_____

Personal Medical History (PLEASE CHECK ALL THAT APPLY)

☐ Anemia/Sickle Cell
☐ Bleeding disorder / Blood transfusion in past
☐ Blood clots in your legs or lungs

☐ Epilepsy, convulsions, seizures, or "fits"
☐ Glaucoma
☐ Migraine or severe headaches
With aura (seeing spots or loss of vision) ☐ Yes ☐ No
☐ Psychiatric / Nervous Disorder / Anxiety
☐ Depression / Suicidal tendencies

☐ Heart disease
☐ Heart murmur / irregular heart rhythm
☐ High blood pressure/hypertension
☐ High cholesterol

☐ Asthma: Do you use an inhaler? ☐ Yes ☐ No
Recent oral steroid use? When _____
☐ Bad chest pains or unusual shortness of breath
☐ Lung disease
☐ Sleep apnea

☐ Diabetes, hypoglycemia, or sugar in your urine
☐ Eating disorder, type _____
☐ Hepatitis, type _____
☐ Liver disease
☐ Adrenal disease
☐ Bladder or kidney infection
☐ Kidney disease

☐ Lupus / Autoimmune disease
☐ Thyroid disease
☐ Cancer, type _____
Oral steroid use? When _____
☐ Tubal/uterine infection /Pelvic Inflammatory Disease
☐ Surgery to cervix or uterus _____
☐ Intrauterine device (IUD) in place now

☐ Tobacco use, packs per day_____
☐ Alcohol use, drinks per week_____

☐ Trichomoniasis/ Bacterial Vaginosis or other vaginal infection
☐ Tuberculosis

Allergic to any medications? No/Yes If yes, please list. _____

Do you take any medications? No/Yes If yes, please list. _____

Have you ever been hospitalized/had any surgeries? ☐No ☐Yes If yes, please describe and date_____

_____

Is there anything about the abortion you would like to discuss? _____

Is anyone ☐ hitting/kicking/choking you ☐ saying mean things to you ☐ forcing you to end the pregnancy?

Are you interested in using birth control? ☐Pills ☐Patch ☐Vaginal ring ☐Injection ☐Implant in arm ☐IUD

Please list any other health concerns not listed above. _____

_____

Pharmacy Name and Number _____

Patient Signature _____ **Date** _____

Nurse Signature: _____ Date _____

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ACKNOWLEDGEMENT OR REVIEW OF NOTICE OF PRIVACY PRACTICE

I have reviewed Alamo Women's Clinic of Albuquerque Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____	_____
Patient Name (print)	Date of Birth
_____	_____
Patient Signature	Date
_____	_____
Parent or Legal Guardian Signature	Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of the receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign.

( ) Communication barriers prohibited obtaining the acknowledgement.

( ) An emergency situation prevented us from obtaining acknowledgement.

( ) Other (please specify):

_____

_____

_____

_____

_____