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

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 _____