

Alamo Women's Clinic of Illinois

2800 W Main Street
Carbondale, Illinois 62901

Medical History Form

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

Name _____ Date of Birth _____ Age _____

Medication or Latex Allergies: _____

Please list any current medications that you are taking: _____

Menstrual History:

What was the first day of your last period _____ Spotting since last period Yes No

Lower abdominal pain/pelvic pain Yes No

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

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 _____

Known or suspected fetal anomaly _____

Personal Medical History (YES or NO)

Anemia /iron deficiency Yes No

Cardiovascular disease
(heart disease) Yes No

Diabetes Mellitus Yes No

Hemorrhagic disorder Yes No

IUD in place Yes No

Kidney Failure Yes No

Liver Disease/Tumor Yes No

Psychiatric Diagnosis Yes No

Depression/suicidal ideation Yes No

Asthma Yes No

Cerebrovascular Accident
(stroke) Yes No

Currently ill or sick Yes No

Endometrial ablation Yes No

Fibroids Yes No

Hemorrhage after
delivery or abortion Yes No

History of uterine surgery
(including c-section) Yes No

HIV/AIDS Yes No

Infection in uterus/tubes/
ovaries Yes No

Recent STI and or PID Yes No

Seizure Disorder Yes No

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?

Chronic adrenal failure Yes No

Concurrent or longstanding
systemic corticosteroid use Yes No

Inherited porphyria Yes No

Respiratory disorder Yes No

Known or suspected
ectopic pregnancy Yes No

Condition precluding
outpatient vacuum aspiration Yes No

Access to telephone, ER care
transportation Yes No

Escorted ride home Yes No

Drug/alcohol use in last 24 hours Yes No

Sedation preference Yes No

History of drug/alcohol abuse Yes No

Obstructive sleep apnea Yes No

Upper respiratory infection Yes No

Previous sedation/anesthesia Yes No

Problems with sedation/anesthesia Yes No

Other not listed _____

Patient Signature _____ **Date** _____

Nurse Signature: _____ **Date** _____