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 have 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 (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 pregnancy____

☐ 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 ☐ None

Would you like to see your pregnancy tissue after the abortion? ☐ Yes ☐ NO ☐ I would like more information

Patient Signature ____ **Date** ___________________________

Nurse Signature: ____ Date ___________________________