Bristol Women's Health Medical History Form

Date #_____

Legal Name_____
Preferred Name_____
Gender Identity/Pronouns_____
Hispanic Origin YES [ ] NO [ ] Race_____
Marital Status_____
Highest Grade Completed_____
Age_____Date of Birth_____
Address_____
City_____State_____Zip_____
Phone_____
Can we contact you at the above phone number and leave a message if needed?
YES [ ] NO [ ]
Email_____
How did you find out about us?
_____

In case of Emergency Notify*
Name_____
Phone_____
Relationship_____

Remember, in an emergency, this person would be informed of your abortion.

First day of your last menstrual period
Month_____Day_____Year_____
Was it a normal period? YES [ ] NO [ ]
Total number of pregnancies prior to current pregnancy #_____
Number of live births#_____
Previous vaginal delivery YES [ ] NO [ ] #_____
Previous C-Section YES [ ] NO [ ] #_____
When?_____
Previous Ectopic YES [ ] NO [ ] #_____
Previous Miscarriage YES [ ] NO [ ] #_____
Did the miscarriage require a D&C ? YES[ ] NO [ ]
Medical Abortion YES [ ] NO [ ] #_____
Surgical Abortion YES [ ] NO [ ] #_____
Any complications? YES [ ] NO [ ]
If yes, please explain_____
Were you using birth control at the time of this pregnancy? YES [ ] NO [ ]
If yes, what type?_____
Are you interested in being prescribed birth control today? YES [ ] NO [ ]
Any problems from birth control you used in the past? YES [ ] NO [ ]
If yes, explain_____
Do you smoke? YES [ ] NO [ ]
Do you vape? YES [ ] NO [ ]
Are you or have you ever been addicted to any substances? YES [ ] NO [ ]
If yes, what substances and when?_____
Height _____ Weight_____

Chart #_____

Do you have any allergies to medications, drugs, food, latex? YES [ ] NO [ ]
If yes, please list _____
_____
Are you taking any prescription, over the counter, or herbal medications/supplements?
If yes, please list _____
_____
If you have any of the following, check the appropriate box. (Check as many boxes as may apply)

A. Infectious disease YES [ ] NO [ ]
B. Previous surgery YES [ ] NO [ ]
C. Sexually transmitted infection YES [ ] NO [ ]
D. Diabetes YES [ ] NO [ ]
E. Bleeding/clotting disorder YES [ ] NO [ ]
F. Heart problems YES [ ] NO [ ]
G. Neurological Problems YES [ ] NO [ ]
H. Liver Problems YES [ ] NO [ ]
I. Lung or breathing problem YES [ ] NO [ ]
J. Hearing problems YES [ ] NO [ ]
K. Intestinal problems YES [ ] NO [ ]
L. Kidney problems YES [ ] NO [ ]
M. Have you ever seen a counselor or a psychiatrist? YES [ ] NO [ ]
N. High Blood Pressure YES [ ] NO [ ]
O. Abnormal Pap Smear YES [ ] NO [ ]
P. LEEP/Cone/Cryo YES [ ] NO [ ]
Q. Are you currently breastfeeding YES [ ] NO [ ]
R. Suboxone/Subutex/Methadone/Treatment Program YES [ ] NO [ ]
S. Other (specify)_____
_____
If you have responded YES to any of the above, please use the following space to explain:_____
_____

I hereby declare that I have read the foregoing and know the contents thereof to be true and best to my knowledge. I acknowledge that Bristol Women's Health and its staff rely upon the representation contained herein. If any of these representations are untrue in whole or in part, Bristol Women's Health is hereby absolved from any liability caused by its reliance on such false statements.

Patient Signature Date

Staff Signature Date

_____

Provider Signature **Date**