

Instructions for completing Womancare Chartpack

1. Print out the entire document, there should be five sheets in addition to this instruction sheet.
2. Print your name, and the date you are having your procedure at the bottom of each page.
3. Fill out each page as best you can. If you don't understand a question, or can't complete it, leave it blank. A counselor will go over each page with you.
4. Make sure you bring the Chartpack to your appointment.

"Personal Medical History"©

Have you ever had or do you now have any of the following?:

	Yes	No	Staff Use Only
1. Diabetes/hypoglycemia/sugar in your urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. High blood pressure/hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Blood clots in your legs or lungs (thrombophlebitis or pulmonary embolus)	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Bad chest pains or unusual shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Heart disease; rheumatic fever; heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Anemia or "low blood"	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Loss of sight or fuzzy vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Migraine headaches or severe headaches often	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Lumps in your breast(s) or breast discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Hepatitis; jaundice; liver or gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Epilepsy, convulsions, seizures or fits	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Bladder or kidney infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Sickle cell anemia: trait or disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Suicidal tendencies or depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
18. Wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please check and fill out following completely as possible.

19. Do you smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	How many per day?: _____
20. Are you allergic to any medications?	<input type="checkbox"/>	<input type="checkbox"/>	What?: _____
21. Do you take medications regularly?	<input type="checkbox"/>	<input type="checkbox"/>	What?: _____
22. Do you faint easily	<input type="checkbox"/>	<input type="checkbox"/>	From what?: _____
23. Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	For what?: _____
(including childbirth)			
24. Have you ever had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	For what?: _____
(Including abortion, C-section, wisdom teeth)			

Do you know what a pap smear is?:	Yes	No	Have you ever had a pap smear?:	Yes	No
When was your last pap smear?:	____/____/____		What were the results?:	_____	
Where?:	_____		Have you ever had an abnormal pap smear?:	Yes	No
			Results:	_____	

Name: _____ MR #: _____ Date: _____ 201__

"Family Medical History"©

Please complete the following for any Blood relative.

	Yes	No	Which relative?
1. Diabetes or hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. High blood pressure/hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Blood clots in legs or lungs (thrombophlebitis or pulmonary embolus)	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Lumps in the breasts or breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Uterine cancer or Cervical cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Cancer of any other kind	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Sickle cell anemia: trait or disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____

Menstrual History

1. How old were you when you first started having periods? _____
2. What is the length of your menstrual period?
(# of days from the start of one period to the start of the next period) _____
3. Are your periods ever more than a month apart? _____
4. What is the usual length of your period? (# days of bleeding) _____
5. How many days of each type of bleeding?:
Heavy: _____ Medium: _____ Light: _____
6. Do you have pains or cramps with your period: Yes No treatment: _____
7. What was the first day of your last period? ____/____/____ Was it normal: _____
8. When was the period before that? ____/____/____ Was it normal: _____

Pregnancy History

1. Total number of times you have been pregnant (including today). _____
2. Have you ever had a tubal or ectopic pregnancy? _____
3. How many children born alive? _____
Please list dates of delivery: _____
4. How many early abortion (under 12 weeks)? _____ when: _____ where: _____
5. How many late abortions (over 12 weeks)? _____ when: _____ where: _____
6. How many miscarriages? _____ when: _____ reasons: _____
7. Any problems with pregnancies? Yes No If yes, explain: _____
8. How many living children do you have now? _____
9. Do you plan future pregnancies? Yes No If yes, how soon?: _____

Have you ever had or do you now have any of the following:

	Yes	No	Staff use only
1. Yeast infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Trichomonas, Gardnerella or bacterial vaginosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Infection in your tubes or uterus	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Pelvic inflammatory disease (PID)	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Chlamydia, gonorrhea or other vaginal infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Syphilis, Herpes Simplex II, genital warts	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Cancer of your uterus, vagina or breast(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Tumor or fibroid in your uterus	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Bleeding between periods	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did your mother take hormones (DES; diethylstilbestrol) when pregnant with you? _____

Name: _____ MR #: _____ Date: _____, 201__

INTAKE - A

We want to assure you that all information you give is confidential.

1. Have you had a positive pregnancy test? YES NO
When? _____ Where? _____
2. Were you using any birth control when you became pregnant? YES NO
If yes, what method? _____
3. Have you received any counseling regarding your decision? YES NO
Where? _____
4. Who do you live with? _____
Are they aware? YES NO Supportive? YES NO
5. Any small children or pets in your home? YES NO
Explain? _____
6. Has there been any particular stress in your life recently? (i.e., separation from your partner, death of a loved one, loss of a job, etc.)? _____
7. When was your last visit to a doctor? _____ Why? _____
8. When was your last visit to a dentist? _____ Why? _____
9. Have you had any alcoholic beverages or taken ANY medications or drugs in the last 24 hours.? YES NO
10. When was your last meal? _____ What did you eat and drink? _____
11. Who came with you today? _____ Are they supportive? YES NO

Staff Use Only

RS YES NO From: _____

Contraceptive chosen: _____ Risks and Benefits discussed: YES NO

Contraceptives previously used: _____

Returning here for post-op? YES NO or where: _____

Work/Excuse given: YES NO Number of days: _____ Type of work: _____

Date returning to work: _____ Restrictions discussed YES NO

Anesthesia: R IV Driver: _____ Phone: _____

Comments: _____

Staff: _____ Time: _____

Name: _____ MR #: _____ Date: _____

INTAKE - B

We want to assure you that all information you give is confidential.

Please be honest and complete so that we can give you the best possible individualized care. This form better helps us to understand your specific situation.

1. Are you aware of the alternatives to abortion? YES NO
If yes, please explain what you have explored? _____

Would you like more information? YES NO
2. Is having this abortion **your** decision? YES NO
3. Your definition of abortion is: _____
4. My feelings about this decision to have an abortion are:
 I have some conflicts but feel abortion would be best.
 I have some serious conflicts about my decision.
 I am definite in my thinking and feeling.
5. How do you feel about you abortion decision? _____
6. Have you made any other attempt to terminate this pregnancy? YES NO
If yes, please explain: _____
7. What led you to decide to have an abortion? _____
8. What is your relationship to the man involved? _____
Is he supportive? YES NO UNCERTAIN
Is the relationship continuing? YES NO UNCERTAIN
9. His feeling regarding this pregnancy/abortion are:
 He would like me to continue this pregnancy.
 He feels abortion is the best decision.
 I feel it is my own decision.
 Other: _____
10. How did you feel when you first found out you were pregnant? _____
11. Who have you discussed your decision with? _____
Have they been supportive?: YES NO
Who has been the most helpful to you? _____
12. What concerns you the most today (i.e., someone finding out, not being able to have children in the future, bleeding, etc.)? _____

Staff Use Only

- | | | |
|--|--|--|
| <input type="checkbox"/> R IV Reviewed | <input type="checkbox"/> Informed Consent Reviewed | <input type="checkbox"/> Emergency Contact |
| <input type="checkbox"/> Med Hx Reviewed | <input type="checkbox"/> Post Op Reviewed | |

Name: _____ MR #: _____ Date: _____