WE HEALTH CLINIC
32 E 1st Street, Suite 300
Duluth MN, 55802
(218) 727-3352

Name: _____
DOB: _____
DOS: _____

Medical History – Abortion Services

Legal Name: _____ Name we should call you: _____

Date of Birth: _____ Social Security #: _____

Sex assigned at Birth: _____ Gender Identity: _____ Gender Pronouns: _____

Address: _____ □ *OK to Mail (bills, health communication)*

City: _____ State: _____ Zip: _____ County: _____

Phone #: _____ □ *OK to Text: (appointment reminders, negative test results)*

This information is confidential. It is used for outside funding and statistical purposes.

Race: _____ Hispanic Origin: □ Yes □ No

Education Level: _____ College: □ Yes □ No How many years completed: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ In a Relationship □ Living with partner

Job title: _____ Employer: _____ □ Full time □ Part time

Annual Income: _____ Number of people in your household: _____

Do you have health insurance? □ Yes □ No Do you have Medical Assistance? □ Yes □ No If yes, what state? _____

Sources paying for your medical expenses: □ Savings □ Partner/Spouse □ Medical Assistance □ Private Insurance

Allergies

□ **Yes** □ **No** Do you have any medication allergies? If yes, please list: _____

□ **Yes** □ **No** Do you have a shellfish or iodine allergy?

□ **Yes** □ **No** Do you have any other allergies? If yes, please list: _____

Current Medications

□ **Yes** □ **No** If yes, please list name and dose: _____

_____

Birth Control

□ **Yes** □ **No** Using when you became pregnant? If yes, what _____

□ **Yes** □ **No** Do you want birth control from us today? If yes, what _____

Gynecological History

First day of you last NORMAL menstrual period: _____ Regular cycles? □ **Yes** □ **No**

□ **Yes** □ **No** Do you have any concerns about or symptoms of sexually transmitted infection?

If yes, please give details: _____

Pregnancy History: Please list a number for each. If none, mark 0.

Live Births: _____ Living Children: _____ Cesarean deliveries: _____ Miscarriages: _____

In clinic abortions: _____ Medication abortions: _____ Ectopic/tubal pregnancies: _____

Details of any complications: _____

Name: _____
DOB: _____
DOS: _____

Health History

Do you have any ongoing medical problems? Please list: _____
List any surgeries you have had: _____
□ **Yes** □ **No** Do you know your blood type? _____
□ **Yes** □ **No** Do you smoke cigarettes? How many packs per day? _____ How many years? _____
□ **Yes** □ **No** Do you use street drugs? Which ones? _____
□ **Yes** □ **No** Have you had any alcohol, street drugs, or other mind-altering substances in the last 24 hours?
□ **Yes** □ **No** Do you feel safe in your relationship and in your home?
□ **Yes** □ **No** Have you ever been forced to have sex or been touched against your will?
If yes, do you want to talk about it? □ **Yes** □ **No** Have you had counseling regarding it? □ **Yes** □ **No**

Health History: Have you had any of the following medical conditions?

□ **Yes** □ **No** Abnormal Pap/LEEP _____
□ **Yes** □ **No** Pelvic infection/PID _____
□ **Yes** □ **No** Problems with uterus, ovaries, or fallopian tubes (e.g. fibroids) _____
□ **Yes** □ **No** Anemia/low blood iron _____
□ **Yes** □ **No** Blood transfusion _____
□ **Yes** □ **No** Bleeding or clotting disorder or factor V Leiden _____
□ **Yes** □ **No** Blood clots in vein, leg, brain or lung _____
□ **Yes** □ **No** Heart surgery, significant heart murmur, or other heart problem _____
□ **Yes** □ **No** High blood pressure _____
□ **Yes** □ **No** High cholesterol _____
□ **Yes** □ **No** Asthma, COPD or other lung disease _____
□ **Yes** □ **No** Diabetes or hypoglycemia _____
□ **Yes** □ **No** Hepatitis, liver disease, or jaundice _____
□ **Yes** □ **No** Gallbladder problems _____
□ **Yes** □ **No** Kidney infection or kidney problems _____
□ **Yes** □ **No** GERD or other stomach/intestine problems _____
□ **Yes** □ **No** Immunodeficiency disease (e.g. HIV) _____
□ **Yes** □ **No** Rheumatoid arthritis, Lupus, or other auto immune disorder _____
□ **Yes** □ **No** Steroid use in the last 6 months (e.g. Cortisone, Prednisone) _____
□ **Yes** □ **No** Seizures or Epilepsy _____
□ **Yes** □ **No** Depression or other mental health issues _____
□ **Yes** □ **No** Suicide Attempt _____
□ **Yes** □ **No** Chemical dependency _____
□ **Yes** □ **No** Migraine headaches _____
□ **Yes** □ **No** Tuberculosis _____
□ **Yes** □ **No** Currently breastfeeding _____
□ **Yes** □ **No** Other _____

Do you have any other concerns or questions? _____

To the best of my knowledge, this information is complete and correct.

Patient Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

Reviewed by physician:
_____
Initial and Date