



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: _____
City: _____ State: _____ Zip: _____ County: _____ OK to Mail: (bills, health communication) Yes No
Phone #: _____ OK to Text: (appointment reminders, negative test results) Yes No

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 any other allergies? If yes, please list: _____
 Yes No Do you have a shellfish or iodine allergy?

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:

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 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?
- Yes** **No** 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