WOMEN'S HEALTH HORIZONS

ABORTION HISTORY FORM

HAVE YOU EVER BEEN A PATIENT OF WOMEN'S HEALTH HORIZONS? Y N **WHEN?** _____

HAVE HAD A SONOGRAM FOR THIS PREGNANCY? Y N **WHERE?** _____

DO YOU HAVE ANY INSURANCE THAT MAY COVER THIS VISIT? Y N **NAME OF INS.** _____

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? Y N **WHAT MEDS?** _____

WHO REFERRED YOU TO OUR OFFICE? _____

IN ORDER TO COMPLY WITH STATE REQUIREMENTS, WE NEED YOU TO COMPLETE THIS FORM IN ITS ENTIRETY.
WE APPRECIATE YOUR COOPERATION IN PROVIDING THE FOLLOWING INFORMATION.

PATIENT HISTORY INFORMATION (Please Print) **DATE** _____

PATIENT INFORMATION

NAME _____ _____/_____
(First) (Middle) (Last) (Maiden)

ADDRESS _____
(House Number) (Street) (PO Box)

_____
(City) (State) (Zip) (County)

HOME PHONE # _____ CELL PHONE # _____

DATE OF BIRTH _____ AGE _____ SS# _____

STATE OF BIRTH _____ DRIVER'S LICENSE NUMBER _____

MARITAL STATUS (CIRCLE ONE): MARRIED SINGLE WIDOWED DIVORCED SEPARATED

PERSON TO NOTIFY IN CASE OF EMERGENCY (MUST BE INCLUDED ON HIPPA FORM)

NAME _____ PHONE# _____

ADDRESS _____

EMPLOYMENT INFORMATION

EMPLOYER _____ PHONE* _____

ADDRESS _____

OCCUPATION _____

EDUCATION (INDICATE HIGHEST NUMBER GRADE COMPLETED):

ELEMENTARY _____ (1-8) HIGH SCHOOL _____(9-12) COLLEGE _____ (1-5+)

MEDICAL HISTORY

DATE LAST NORMAL PERIOD BEGAN _____ BLOOD TYPE__ ___ RH_____(verification necessary)

TOTAL # OF PREVIOUS PREGNANCIES _____ # OF CHILDREN NOW LIVING_____ DECEASED_____

DATE OF FIRST LIVE BIRTH _____ DATE OF LAST LIVE BIRTH_____ STILLBORN_____

TOTAL NUMBER OF PREVIOUS MISCARRIAGES_____ DATE OF LAST MISCARRIAGE _____

TOTAL NUMBER OF PREVIOUS INDUCED ABORTIONS _____ DATE OF LAST INDUCED ABORTION _____