CENTRE DE SANTÉ DES FEMMES DE MONTRÉAL
Medical information form

DATE:	AGE:

NOM COMPLET ou carte RAMQ

CURRENT PREGNANCY

Date of last normal menstrual period (first day):

Have you had any bleeding since your last menstrual period (length, color, abundance)?
☐ Yes ☐ No If yes, specify:

Do you have pregnancy symptoms? ☐ Yes ☐ No

If yes, for how many weeks? _____

If yes, specify: ☐ Nausea ☐ Swollen tender breasts ☐ Fatigue ☐ Urinate + ☐ Other

Have you done a pregnancy test?
☐ Yes: ☐ Urinary ☐ Blood
☐ No

If yes, indicate the date and result:
☐ Positive ☐ Negative Date:
☐ Positive ☐ Negative Date:

Have you had an ultrasound? ☐ Yes ☐ No **If yes, indicate the date:**

Place: **Number of weeks:**

PREVIOUS PREGNANCY(IES)

Have you ever had a gynaecological exam? ☐ Yes ☐ No	Have you ever been pregnant? ☐ Yes ☐ No	Are you currently breastfeeding? ☐ Yes ☐ No

Number of vaginal deliveries:	**Date of last:**	**Complications (if applicable):**
Number of births by caesarean:	**Date of last:**	**Complications (if applicable):**
Number of surgical* abortions:	**Years:**	**Complications (if applicable):**
Number of medical abortions:	**Years:**	**Complications (if applicable):**
Number of miscarriages:	**Years:**	**Complications (if applicable):**
Number of ectopic pregnancies:	**Years:**	**Complications (if applicable):**

MEDICAL HISTORY

How would you describe the pain during your normal menstrual period?
☐ Light ☐ Moderate ☐ Severe

Do you take medication on a regular basis?
☐ Yes If yes, specify:
☐ No

Do you currently or have you ever taken any drugs?
☐ Yes If yes, specify:
☐ No

Are you allergic to any medications and/or latex?
☐ Yes If yes, specify:
☐ No

Do you smoke cigarettes?
☐ Yes How many per day:
☐ No

* A surgical abortion is not a surgery. It is done with the use of instruments

MEDICAL HISTORY (continued)

Do you know for sure your blood type?
☐ Yes ☐ No If yes, specify type:

Have you ever been hospitalized / operated?
☐ Yes If yes, specify:
☐ No

Have you ever had one or more sexually transmitted infections?
☐ Yes If yes, specify:
☐ No

Have you ever had an infection of the uterus / tubal?
☐ Yes If yes, specify what year:
☐ No

NOM COMPLET ou carte RAMQ

When was your last PAP smear test? _____

Have you ever presented the following health problems:

Asthma	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Haemorrhage	☐ Yes	☐ No	Hearth problem	☐ Yes	☐ No
Phlebitis/Clot	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Clotting problem	☐ Yes	☐ No	Family history of clotting problem	☐ Yes	☐ No
Others If yes, specify:	☐ Yes	☐ No			
Migraines / Severe headaches	☐ Yes	☐ No			

If yes, neurological symptoms: (loss of vision, flashing lights, blurred vision, numbness, paralysis, etc.)
☐ Yes ☐ No If yes, specify: _____

Do you have any questions about contraceptive methods? ☐ Yes ☐ No
If yes, indicate which one:

☐ Contraceptive pill	☐ Depo-provera	☐ Vasectomy
☐ Contraceptive patch	☐ Calendar	☐ Ligature
☐ Vaginal ring	☐ Intrauterin device	☐ Diaphragm
☐ Condoms	☐ Sympto-thermal method	

Have you ever used birth control methods that you have poorly tolerated?
☐ Yes ☐ No If yes, indicate which one:

Would you use a contraceptive method after the abortion?
☐ Yes ☐ No If yes, indicate which one:

Do you have a family doctor?
☐ Yes ☐ No If yes, indicate their name:

Do you plan on travelling in the next 14 days?
☐ Yes ☐ No If yes, where :

DOCTOR SIGNATURE