Patient Intake Form (Sample: Abortion Services)

Name you would like us to use today: _____Date _____ DoB _____
Other names on your chart or insurance _____
Pronouns you would like us to use today_____
Please share your gender identity _____
Please share your sex assigned at birth: Female _____Male_____Intersex_____Other_____
Sexual history: How would you describe your sexual orientation _____
Have you had sex with (check all that apply):
Cis Men _Cis Women __Transgender Men__Transgender Women__Nonbinary/gender queer__Other____
When you have sex, do you have (check all that apply): Oral___Vaginal_____Anal _____
Obstetrical history:

Previous Pregnancies_____ Deliveries_____ Miscarriages_____ Abortions_____
# of vaginal deliveries _____ # of cesarean sections _____
Previous ectopic pregnancy? No _____Yes _____If yes, outcome?_____
Any previous pregnancy complications? _____

Medications _____
Allergies _____
Medical History:

Body System	Check if yes	Diagnosis/History
Lungs or breathing (e.g. asthma)		
Heart or blood vessels (blood pressure)		
Stomach, abdomen, colon, digestion		
Hormones or blood sugar (e.g. diabetes)		
Bladder, kidneys, reproductive organs, or genitals (other than pregnancies)		
Head, nerves (e.g. seizure disorder)		
Mental health		
Blood or clotting (e.g. bleeding disorders clots, and/or anemia)		
Surgeries (other than cesarean section)		

----------Below this line to be completed by healthcare team----------
Physical Exam:
BP_____ Pulse_____ Temp _____

Heart:	Bimanual Exam:
Lungs:	Uterine size by bimanual exam _____
Abdomen:	Other:

Pregnancy Dating:
First day of last menstrual period _____
Optional Testing (to be performed as indicated):
Pregnancy test and date _____
Hb/Hct _____ Blood type _____
Rh-iIG given (if indicated) Yes _____ No ____
HIV testing offered Yes _____No_____
Accepted? Yes _____No_____
Other health testing? (e.g., pap)_____
Ultrasound (TA / TV / Both) _____
Today's pregnancy dating by LMP _____
Today's pregnancy dating by ultrasound _____

Desired type of abortion: Medication / Procedure
Pain management plan: _____
Antibiotics given (for procedural abortion):
Yes Type _____
Desired Contraceptive Counseling Yes __No _
If yes, desired method: _____
Prescribed, Placed, or Scheduled for Return:
_____
Instructions given: Yes _____ No _____
Follow-up visit (if needed): Date____Time _____