

**BEACON WOMENS CENTER**

Date \_\_\_\_\_  
Marital status \_\_\_\_\_  
Race \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_  
Place of birth \_\_\_\_\_ Number of school years completed \_\_\_\_\_  
Occupation \_\_\_\_\_ Religious Preference \_\_\_\_\_  
Who referred you to us? \_\_\_\_\_

Were you counseled?  Yes  No  
Have you had a pregnancy test?  Yes  No Test results  Positive  Negative  
Where did you have your pregnancy test? \_\_\_\_\_ What Type?  Blood  Urine

**GYNECOLOGICAL HISTORY**

What was the first day of your last normal period? \_\_\_\_\_  
Was it normal &  Yes  No Are your periods regular?  Yes  No  
How old were you when you began menstruation? \_\_\_\_\_  
Have you had spotting or bleeding since your last period? \_\_\_\_\_  
Do you have: Cramps  Yes  No Discharge  Yes  No  
Irregular bleeding  Yes  No Itching or burning  Yes  No  
Heavy bleeding  Yes  No Pain during intercourse  Yes  No  
Other \_\_\_\_\_

Date of your last pelvic exam \_\_\_\_\_ Date of your last Pap smear \_\_\_\_\_ Results \_\_\_\_\_  
Have you ever been pregnant before? \_\_\_\_\_ How many times? \_\_\_\_\_ Number of children \_\_\_\_\_  
How many: Full Term deliveries \_\_\_\_\_ Miscarriages \_\_\_\_\_  
Premature deliveries \_\_\_\_\_ Abortions \_\_\_\_\_  
Still births \_\_\_\_\_ Caesarean sections \_\_\_\_\_

Date of last delivery \_\_\_\_\_ Date of last abortion \_\_\_\_\_  
Did you have any complications with previous pregnancies, deliveries, abortions or miscarriages?  Yes  No If yes, explain \_\_\_\_\_

Have you had excessive bleeding or other problems following any previous delivery, abortion, miscarriage or IUD use?  Yes  No  
If yes, explain \_\_\_\_\_  
Have you ever had infection in your tubes, ovaries, or uterus (womb)?  Yes  No If yes, explain \_\_\_\_\_

Have you ever had an ectopic or tubal pregnancy?  Yes  No If yes, which tube was removed? \_\_\_\_\_  
Have you ever had a Dilatation and Curretage (D&C) before?  Yes  No If yes, explain \_\_\_\_\_

Were you using a birth control method when you became pregnant this time?  Yes  No  
If yes, what method \_\_\_\_\_

Methods of contraception previously used:  
 Condom  None  
 Diaphragm  Pills  
 Foam  Rhythm  
 IUD  Suppositories  
Other \_\_\_\_\_

Have you had any problems with birth control methods used in the past?  Yes  No If yes, explain \_\_\_\_\_

**PAST MEDICAL HISTORY**

Previous Hospitalizations, reason and operations performed \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to  Local anesthetics  Tetracycline  Penicillin  PhisoHex  Betadine (Iodine)  
 Other \_\_\_\_\_

Are you taking any medications now?  Yes  No If yes, what \_\_\_\_\_

Do you have any specific medical problems? \_\_\_\_\_

Does any one in your family have any specific medical problem(s)? \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No Why? \_\_\_\_\_

Have you ever had any of the following conditions? Check if yes and give date when condition occurred in space below:

- |  |  |
|--|--|
| <input type="checkbox"/> _____ Aids                        | <input type="checkbox"/> _____ Herpes                                |
| <input type="checkbox"/> _____ Anemia (low blood)          | <input type="checkbox"/> _____ High blood pressure                   |
| <input type="checkbox"/> _____ Asthma                      | <input type="checkbox"/> _____ Intestinal problems or ulcer          |
| <input type="checkbox"/> _____ Blood clotting disorder     | <input type="checkbox"/> _____ Kidney, bladder infection             |
| <input type="checkbox"/> _____ Blood clots, varicose veins | <input type="checkbox"/> _____ Liver disease                         |
| <input type="checkbox"/> _____ Breast tumor or lump        | <input type="checkbox"/> _____ Lung problems or TB                   |
| <input type="checkbox"/> _____ Cancer                      | <input type="checkbox"/> _____ Mitrovalve prolapse                   |
| <input type="checkbox"/> _____ Diabetes, sugar             | <input type="checkbox"/> _____ Ovarian cysts                         |
| <input type="checkbox"/> _____ Disease of uterus, ovaries  | <input type="checkbox"/> _____ Pelvic Inflammatory Disease (PID)     |
| <input type="checkbox"/> _____ Dizzy or fainting spells    | <input type="checkbox"/> _____ Pneumonia                             |
| <input type="checkbox"/> _____ Drug addiction              | <input type="checkbox"/> _____ Psychiatric care                      |
| <input type="checkbox"/> _____ Epilepsy                    | <input type="checkbox"/> _____ Rheumatic fever                       |
| <input type="checkbox"/> _____ Excessive bleeding          | <input type="checkbox"/> _____ Rh – (Neg) Blood                      |
| <input type="checkbox"/> _____ Fibroid tumors              | <input type="checkbox"/> _____ Severe chest pain                     |
| <input type="checkbox"/> _____ Frequent severe headaches   | <input type="checkbox"/> _____ Sickle Cell Anemia (disease or trait) |
| <input type="checkbox"/> _____ Gonorrhhea (V.D.)           | <input type="checkbox"/> _____ Stomach ulcer                         |
| <input type="checkbox"/> _____ Heart disease or problems   | <input type="checkbox"/> _____ Syphilis (V.D.)                       |
| <input type="checkbox"/> _____ Hepatitis                   |  |

.....  
Patient's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_ Social Security No. \_\_\_\_\_

I hereby authorize Beacon Womens Center to release my medical records to the physician or clinic listed below. I also authorize my follow-up doctor or clinic to release pertinent follow-up records to Beacon Womens Center.

\_\_\_\_\_  
Signature

Name of Doctor or Clinic you will be seeing for follow-up care \_\_\_\_\_

Patient Name \_\_\_\_\_

Chart No. \_\_\_\_\_

### Counseling Information

Today you have made the choice to have an abortion. This may be the most difficult decision that you will ever make. You will meet with a counselor, who will help you with any questions, concerns, or conflicts that you might have. Your understanding of the abortion and your personal responsibility for this decision are essential to your consent, which will be obtained before the procedure. The staff of Beacon Women's Center would like you to know that we realize the complexity of this situation and that we are here to support you in your decision today, tomorrow and always.

Please answer the following questions. All information is confidential.

1. Have you talked with anyone about your decision to have an abortion?  
\_\_\_\_\_ Physician    \_\_\_\_\_ Counselor    \_\_\_\_\_ Family    \_\_\_\_\_ Friends    \_\_\_\_\_ Partner
2. Who is supporting you in your decision?  
\_\_\_\_\_ Family    \_\_\_\_\_ Friends    \_\_\_\_\_ Partner    \_\_\_\_\_ No One
3. Do you feel that you have, in any way, been pressured into having the abortion?  
\_\_\_\_\_ Yes    \_\_\_\_\_ No    \_\_\_\_\_ Comments
4. Are you sure that you want to have an abortion?  
\_\_\_\_\_ Yes    \_\_\_\_\_ No
5. What are you most concerned about today? \_\_\_\_\_  
\_\_\_\_\_
6. Is there anything else that you think we should know? \_\_\_\_\_  
\_\_\_\_\_

Post procedure counseling is available to all Beacon patients. This service is provided individually or as part of a group. As always, our services are confidential. Please do not hesitate to call on us if we may help you in any way. We recognize your value as a person and feel that your life has priority over any potential life.

STATE OF ALABAMA        }  
COUNTY OF MONTGOMERY }

### CONSENT TO STD TESTING

"I hereby acknowledge that current Alabama law and regulations governing the operation of Beacon Women's Center include a provision requiring all patients undergoing a pregnancy termination procedure to undergo tests for gonorrhea, syphilis, and the HIV virus (AIDS), if they consent to such tests. I have been informed of this regulation by Beacon Women's Center, as well as the purposes for the tests. I understand that these tests are available for an additional fee. I also understand that if I voluntarily receive any of these tests, I will be contacted by the County Health Department (should positive results be obtained) for treatment, counseling, and follow-up. I hereby request the following test(s)."

Gonorrhea            Syphilis            AIDS   

\_\_\_\_\_  
Signature.

### REFUSAL OF CONSENT TO STD TESTING

"I hereby acknowledge that current Alabama law and regulations governing the operation of Beacon Women's Center include a provision requiring all patients undergoing a pregnancy termination procedure to undergo tests for gonorrhea, syphilis, and the HIV virus (AIDS), if they consent to such tests. I have been informed of this regulation by Beacon Women's Center, as well as the purposes for the tests. I understand that these tests are available for an additional fee. I hereby refuse to consent to the performance of these tests."

\_\_\_\_\_  
Signature