MEDICAL HISTORY

BLOOD TYPE_____
SS#_____

NAME_____AGE____DATE OF BIRTH_____

ADDRESS_____
STREET CITY STATE ZIP

Telephone
H(____)_____Cell(____)_____W(____)_____

What is your occupation?_____Describe your job to us_____

List names and relationships of people we can **NOT** talk to_____

Are You interested in birth control? Y or N type_____
Are you presently taking birth control pills? Y or N type_____
First day of your last normal period? _____
Do you usually have cramps with your period? Y or N Mild_____Medium_____Severe_____
Do you usually have clots with your period? Y or N
Do you have any allergies to medications? Y or N type_____
List any medications you are currently taking? _____
Do you smoke? Y or N how many years?_____ # packs per day _____
Approximate date of last Pap Smear _____ Result _____

FAMILY MEDICAL HISTORY

Has anyone in your immediate family had any of the following:

Heart Disease	Y or N	Family Member_____
High Blood Pressure	Y or N	Family Member_____
Varicose Veins	Y or N	Family Member_____
Cancer	Y or N	Family Member_____
Diabetes	Y or N	Family Member_____
Breast Tumors	Y or N	Family Member_____
Sickle Cell Anemia	Y or N	Family Member_____

PATIENTS PREGNANCY HISTORY

Have you had a positive pregnancy test Y or N Where &
When_____
Total Number of Pregnancies including this one _____
# of Children_____What are there ages?_____Did you deliver Naturally or have a C-Section?_____if c-section why?_____
# of Miscarriages_____When?_____How many weeks were you?_____
#of Abortions_____# of Stillbirths_____# of Ectopic Pregnancies_____
Date of last pregnancy_____

PATIENTS MEDICAL HISTORY

Have you ever had any of the following:		Date & Treatment:
Anemia	Y or N	
Asthma	Y or N	
Cancer	Y or N	
Chest Pains	Y or N	
Diabetes	Y or N	
Epilepsy/Convulsions/Seizure Disorder	Y or N	
Heart Disease/Murmur/Mitral Valve Prolapse	Y or N	
Hemophiliac	Y or N	
Hepatitis (please list which one)	Y or N	
High Blood Pressure	Y or N	
Hypoglycemia (low blood sugar)	Y or N	
Kidney Disease/Stones	Y or N	
Liver Disease	Y or N	
Pelvic Inflammatory Disease (PID)	Y or N	
Panic Attacks/Nervous Disorders/Depression	Y or N	
Rheumatic Fever	Y or N	
Shortness of Breath	Y or N	
Thyroid Disease	Y or N	
Tuberculosis	Y or N	
Urinary Tract Infections	Y or N	
Vaginal Infections/Yeast/Bacterial Vaginosis	Y or N	
Varicose Veins	Y or N	
Sexually Transmitted Infections	Y or N	
Ever Been told not to take Birth Control	Y or N	

Have you ever used any street drugs or are you using any now? Y or N If yes which kind?_____

_____

Have you ever been on pain medication for more than a week? Y or N If yes which kind and how long were you on it for_____

_____

Previous or Current Medical Problems_____

Please state the type of service you desire today_____

How were you referred to A Woman's World Medical Center?_____

_____

_____ _____

Patients Signature Date

A Woman's World Medical Center, Inc.

Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. **YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This notice is provided pursuant to Florida Law.

Patient Signature_____

INFORMATION AND FACTS CONCERNING "TERMINATION OF PREGNANCY"

*NOTE: AFTER EACH PARAGRAPH PLEASE WRITE YOUR INITIALS. *

WHAT IT IS- A surgical procedure to terminate a pregnancy within sixteen (16) weeks from the last Day of your last normal period.

HOW IT IS DONE AT THIS FACILITY AND THROUGHOUT THE COUNTRY.

1. You will be examined by Dr._____ who is an OBGYN. The doctor Will determine the length of your pregnancy by a pelvic exam or ultrasound._____

2. A speculum is inserted into the vagina for the cervix to be visible by the doctor. A local Anesthetic is injected into and around the cervix to numb this area. (cervix is the opening To the uterus) In some cases patients are given sedation to make them less nervous During the procedure._____

3. The opening of the cervix is gradually opened by a series of narrow rods called dilators, Each a little thicker than the one before. You may or may not feel cramps during this process. The largest dilator may be as thick as a fountain pen, depending on how many weeks you Are._____

4. When the cervix is opened enough to admit a blunt tipped instrument called a cannula (straw Like in appearance) is inserted into the opening. The cannula is attached to the vacuum Aspiration machine, which is then turned on to empty the uterus._____

5. After the uterus has been emptied by gentle suction, a small spoon shaped instrument called A curette is used to determine if the uterus is empty._____

*NOTE: THIS PROCEDURE IN MOST CASES TAKES 3 TO 5 MINUTES.

POSSIBLE PROBLEMS AND COMPLICATIONS- As with any kind of surgery, complications can occur with early abortion. Early abortion by vacuum aspiration is, however, very safe. Fewer than 1 woman in 100 will have serious complication, including, but not limited to:

INFECTION - Infection is caused by germs from the vagina and cervix getting into the uterus. The risk of infection associated with early abortion is less than 1 in 100 cases. Such infections usually respond to antibiotics but, in some cases, a repeat vacuum aspiration or hospitalization is necessary._____

HEMORRHAGE - Bleeding from the uterus heavy enough to require treatment occurs rarely. Bleeding heavy enough to require blood transfusion occurs less than 1 in 1,000 cases. Medication may be required to help the uterus contract, (go back to normal size) a repeat vacuum aspiration or dilation and curettage or rarely surgery may be necessary._____

CERVICAL TEAR- The cervix is sometimes torn during the procedure. The frequency of this event is less then 1 in 100 cases. Stitches may be required to repair the cervix._____

INCOMPLETE ABORTION - Occasionally, the contents of the uterus may not be completely emptied. The frequency of this event is less than 1 in 100 cases. This can lead to infection, hemorrhage, or both. To remove the tissue, it may be necessary to repeat vacuum aspiration or perform a dilation and curettage at the clinic or in the hospital. In rare instances, surgery may be required._____

PERFORATION- Rarely, an instrument may go through the wall of the uterus. The frequency of this event is about 2 per 1,000 cases. Should this happen, hospitalization is required for observation and/or completion of the procedure. Perforation rarely requires surgery to repair the uterus. This can include hysterectomy (removal of the uterus), which makes it impossible to have children. The frequency of hysterectomy in this setting is about 1 in 10,000 cases. Very rarely does this occur._____

FAILURE TO TERMINATE PREGNANCY - Rarely, does early termination fail to terminate a pregnancy. The likelihood of this event is about 2 per 1,000 cases. In such cases another suction is required._____

DEATH - Early abortion is one of the safest procedures in medicine today. Information from the Center for Disease Control indicates that the risk of death from early abortion is about 1 in 100,000 cases. The risk of death associated with tonsillectomy is about 3 per 100,000 cases. The risk of death from childbirth is at least 7 times greater than termination._____

ANESTHESIA REACTION - In some cases, local sedation can cause severe reactions or shock. Twilight might render the patient unconscious in a few patients. However in a small number of cases, severe complications which may result in injury, disability and very rarely death._____

IMPACT OF ABORTION ON FUTURE PREGNANCIES - At this point, there is no clear evidence that one early abortion carries any risk to future pregnancies. Women have a slightly increased risk of premature birth or miscarriage after the third early abortion with future pregnancies. Some studies have shown this while others have not._____

INFORMED CONSENT TO TERMINATE MY PREGNANCY. GIVE ANESTHESIA. PERFORM OTHER MEDICAL SERVICES AND AUTHORIZE RELEASE OF MEDICAL RECORDS IF NECESSARY.

I,_____, Age_____, hereby give my consent to and request and authorize Dr._____ and assistants of his/her choosing to perform an abortion on me. I understand that the purpose of an abortion is to end my pregnancy.

I understand the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the results of this procedure. I understand that the physician, medical personnel and other assistants will rely on statements I have made, the medical history I have given and other information in determining whether to perform the procedure or the course of treatment for me and I warrant that I have made a full, complete and truthful disclosure.

ADDITIONAL PROCEDURES If during the course of the abortion procedure, any unforeseen conditions or complications arise, and the doctor in his/her professional medical judgment decides that different or additional procedures including, but not limited to anesthesia or blood transfusion or the association of another doctor, or hospitalization at a hospital may be necessary, I give my permission for my parent (or legal guardian where applicable) or other person I name set forth on the next page to be notified by the doctor or staff member. The correct identity, and phone number of my emergency contact is on the next page.

LABORATORY I consent to diagnostic studies, tests, sonograms, x-ray examinations and any other treatment or courses of treatment relating to the diagnosis of my condition or procedures set forth herein. I understand the purpose of a sonogram here is to determine gestational size only and NOT to rule out and determine fetal abnormalities and deformities. I also consent to the disposal of any tissue or other parts of contents of my uterus (womb) which may be removed during the abortion at the discretion of the physician of the clinic.

EMERGENCY If I develop a fever, heavy bleeding, severe cramping, pain or any other symptoms, I agree to notify the clinic at once. I have been given an emergency contact telephone number which I can call 24 hours a day for assistance. My failure to give notice releases the doctor and/or clinic from any responsibility to me.

FOLLOW-UP I have been advised to return to the clinic for a follow-up examination within 3 weeks after today. I understand that this exam is needed to be sure that no complications or other problems have appeared, that I am not still pregnant, and that the healing process has gone on properly. I agree to follow the instructions provided to me and take my medications as directed. I further agree to obtain the follow-up care either here or at some place else at my own expense. My failure to follow instructions or obtain care relieves the doctor and/or clinic of any responsibility to me.

I GIVE MY CONSENT FOR THE ABORTION FREELY AND WITHOUT COERCION By signing this form, I acknowledge that I have read or had this form explained to me, that I fully understand its contents, and that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily. All blanks or statements requiring completion were filled in and all statements I do

not approve of were stricken before I signed this form. I also have received additional information including but not limited to the materials listed below relating to the procedure described herein. I understand that I can request and receive a sample copy of this consent if I choose to do so.

ADDITIONAL MATERIALS USED OR FURNISHED TO PATIENT

Aftercare instructions with 24 hour emergency number, appointment card with follow-up time and date. Antibiotics information and/or birth control pills or prescription/Depo Provera/Ortho Evra Patch prescription/Nuvaring prescription. Information sheet on how to continue Birth Control with follow-up care.

IN CASE OF EMERGENCY, PLEASE CONTACT

NAME:_____PHONE:_____
Does the above person know you are here? Y or N Relationship_____

Would you like to see your pregnancy tissue? Y or N

_____ _____
PATIENT SIGNATURE DATE COUNSELOR SIGNATURE

_____ _____
PARENT SIGNATURE DATE WITNESS

A Woman's World Medical Center, Inc.

Patients Name _____ Date _____

I have been informed that 2-3 weeks after my abortion I have a follow-up exam (The cost is **$60.00**). This will insure my health after the termination. I have also been informed that if I have any concerns or problems before my follow-up I am to contact A Woman's World Medical Center first. I am aware that if I do not contact a Woman's World Medical Center or return for the follow-up exam I will not hold the Doctor or A Woman's World Medical Center responsible for any further medical problems. Future office check-ups are charged extra.

In the event that I change my mind and the termination is not performed there will be a fee of **$250.00** to cover the office visit, counseling, lab work performed here, ultrasound, doctor examination and medications given. If surgery is only postponed at the doctors recommendation, payment will be credited towards the termination and you pay the remaining balance, if any when you return.

In the event that you have been pre-counseled and you cancel your appointment there will be a fee of **$200.00** to cover office visit, counseling, lab work performed here, and ultrasound. If you need to reschedule your appointment there will be a fee of **$200.00**, and that does not go towards the cost of the procedure when you return. The only exceptions would be if you are too early and we advise you to wait a week or two.

In the event that you fall under the Parental Notification Law there will be a fee of **$200.00** for your initial visit to cover the office visit, lab work performed, ultrasound and counseling. When you come back for the surgery you will owe the balance of the termination (you must come to your next scheduled appointment or the **$200.00** paid is forfeited and owed again on the day of the procedure.)

You may receive a lab bill in the mail from Quest Diagnostics. This would be for lab fees that doctor feels are necessary, (after the termination doctor will determine if it is necessary to send tissue to lab for inspection to confirm the termination of pregnancy.) You will be notified in advance if this is necessary.

I am aware that neither the Doctor nor A Woman's World Medical Center is not responsible for any of my personal articles such as money, jewelry, or any other personal valuables brought into the office for my termination.

_____ _____

Patients Signature Witness Signature

RV 03/09

A WOMAN'S WORLD MEDICAL CENTER, INC.
503 SOUTH 12TH STREET
FT. PIERCE, FLORIDA 34950

*****CONFIDENTIAL*****

All information on this form is held in the strictest confidence. We ask these questions so that we may better understand your unique situation and be better prepared to serve your individual needs.

NAME _____

How do you feel today about having your pregnancy terminated?

_____

_____

Do you have any fears about the termination? _____

Do you have any doubts about your decision today to terminate your pregnancy?

_____

What is your relationship with the man involved in this pregnancy?

_____

****

COUNSELOR NOTE'S

_____

_____

_____

_____ _____

COUNSELOR SIGNATURE TODAYS DATE

A WOMAN'S WORLD MEDICAL CENTER
503 S. 12TH ST. FORT PIERCE, FL 34950

POST OPERATIVE CONTACT SHEET

Please fill out the following information as accurately as possible, in the event that we need to contact you after your abortion. We will contact you only if it is medically necessary. We will leave a message only as you indicate, as we take every precaution in maintaining your confidentiality and privacy concerning your visit with us. Please understand that it is for your protection that we require a telephone number and complete address. Thank you for your cooperation.

****

PLEASE PRINT

Full Name_____

Mailing Address_____
STREET CITY STATE ZIP

We will be contacting you about your follow up visit: Would you like us to email, phone or mail you?_____
If Email what email address?_____

Phone ( )_____Best time to call_____ AM or PM

May we call you at work?	Y or N	Phone#_____
Okay to leave a message at work?	Y or N	With whom_____
Okay to identify A Woman's World?	Y or N	
Okay to leave a message at home?	Y or N	
Okay to say "Please have her call her dr.'s office?	Y or N	With whom_____
May we mail to your home address?	Y or N	

If no please give an address to which we may mail you information:

_____
STREET CITY STATE ZIP

May we leave a message with a friend? Y or N

Friends Name_____ Friends #_____

Do you have a nickname you go by_____

The above information is accurate and by filling out this form, I give permission for the above information to be used in post-operative contact of me, if necessary. I understand that all information given here about me is kept in strictest confidence.

_____ _____
PATIENT SIGNATURE DATE REV 03/09

A WOMAN'S WORLD MEDICAL CENTER, INC.
503 S. 12TH STREET, FT. PIERCE, FL 34950
772-460-1506

TRANSPORTATION INFORMATION

I,_____, understand that if I am taking either the oral or
Patients Name
twilight sedation that I need someone to drive me home. The person that will be picking me up is_____ and you can contact them 30 minutes before
Drivers Name
I am ready at this phone number_____. I also understand that
Area Code and Phone Number
If after 3 attempts to contact my ride, if there is no answer or return call that A Woman's World Medical Center will call me a taxi and I will cover all charges.

_____

Patients Signature Date

A WOMAN'S WORLD MEDICAL CENTER, INC.

503 S. 12TH STREET, FT. PIERCE, FL 34950 772-460-1506

POST OPERATIVE CARE

Now that you have had your abortion, there are a few things we need to tell you……

1. Please use regular size maxi pads only. Regular tampons can give you an infection. USE PADS FOR TWO WEEKS!!!

2. Start your antibiotics today after you have eaten.

3. Get plenty of rest for the next couple days, and drink lots and lots of water.

4. Check your temperature for the next couple of days, it may run as high as 100.4

5. The bleeding you'll have after an abortion varies. You may not bleed at all for the first few days and then start cramping and bleeding. Any kind of bleeding is normal as long as you don't bleed heavier than two pads in one hour. Also you may not get your regular period for two or three months.

6. You may or may not pass clots, some may be as big as fifty cent pieces. If clots are bigger than that call us at the above number.

NO NO NO NO NO NO NO NO NO NO NO NO NO NO NO

FOR THE NEXT TWO WEEKS DO NOT DO THE FOLLOWING……..

*Do not pick up heavy objects, like children, or anything that's heavier than 10 lbs.

*No tub baths, showers are fine.

*No tampons, regular pads only

*No Sex

*No Swimming

*No Strenuous exercise or activity

Please adhere to these rules and you shouldn't have any problems, in the event that you do have problems please call us first. We are the experts……Thank You…….Staff/Doctor

STATS ______

NAME:______________________________

AGE:_______________________________

RACE:______________________________

MARITAL STATUS:____________________

CITY:______________________________

REFERRED BY:_______________________

~~~~~~

OFFICE USE ONLY

WEEKS:__________ SEDATION_______

PRIOR ABS:_______

RH TYPE:_________

DATE OF AB:______________________
~~~~~~