North Florida Women's Services

2412 West Plaza Drive, Tallahassee, FL 32308 - 850.877.3183

MEDICAL HISTORY

Name:_____ Age:_____ Date of Birth:_____ Last 4 of SSN:_____
Address:_____ City:_____ State: _____ Zip: _____
Highest Education Level_____
County of Residence:_____ Marital Status:____ Race:_____ If Asian, from where? _____
If Hispanic, from where? _____ Preferred method of contact: ( ) Home ( ) Cell ( ) Work
Home/Cell Phone ( )_____ Message Instructions: ( ) Detailed message ( ) Only that NFWS called
Work Phone ( )_____ Message Instructions: ( ) Detailed message ( ) Only that NFWS called
Emergency Contact:_____ Relationship:_____
Emergency Contact # ( )_____ Are they informed of your procedure? ( ) YES ( ) NO

CONDITIONS: *check all that you have now or have had in the past and note YEAR, TREATMENT AND OUTCOME*

	Abnormal pap smear		Hepatitis
	Abnormal vaginal bleeding/excessive bleeding		Herpes
	Anemia		High blood pressure/arterial low blood pressure
	Asthma		HIV
	Blood clots in vein or artery		Kidney disease/urinary tract infection
	Breast lump/surgery		Liver disease
	Cancer		Migraines
	Chlamydia		Mitral valve prolapse/stenosis
	Circulatory problems/bleeding disorder		Mononucleosis
	Colitis/Bowel problems/IBD		Ovarian cysts
	Diabetes		Pelvic inflammatory disease (PID)
	Digestive problems		Porphysia
	Dizzy/Fainting spells		Recurrent vaginal infections
	Emotional problems/Eating disorder/Psychiatric care		Severe chest pain
	Endometriosis		Severe headaches
	Epilepsy/seizures		Sickle cell trait/anemia
	Glaucoma		Stroke
	Gall bladder disease		Substance abuse
	Genital warts (HPV)		Syphilis
	Gonorrhea		Thyroid problems
	Gynecological surgery		Tuberculosis
	Heart attack or disease		Uterine fibroids
	Heart murmur		Other

How much do you currently weigh?_____ Do you smoke?_____ If yes, amount? _____
Do you consider yourself to be in good health? _____ If no, please explain:_____
Are you allergic to any of the following medications? If yes, please note reaction and how you found out you were allergic:
Tylenol/Acetaminophen _____ Latex _____ Motrin/Ibuprofen _____ Amoxicillin _____
Lidocaine _____ Doxycycline _____ Iodine or shellfish _____ Methergine _____
Metronidazole _____ Fluconazole _____ Promethazine _____ Other _____
Are you currently on medications of any kind (prescribed, over the counter, or street drugs)? If yes, please note type, amount, and purpose: _____
Have you ever been hospitalized? _____ If yes, please explain: _____
If I am referred to or choose to go to a hospital or other facility for an abortion-related complication, I authorize NFWS to release my medical records relating to this procedure to the hospital/other facility. ( ) Yes ( ) No

Patient Signature Date Reviewed By

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PATIENT INFORMATION

Each member of our staff is committed to making you as comfortable as possible. We realize that the decision to have an abortion may be easy for some women and difficult for others. We would like to have a better understanding of your individual situation and needs. The information you give is confidential.

Name: _____

Do you feel you are involved in an emotionally, physically, or sexually abusive relationship?
_____

If yes, please explain: _____

Would you like information on assistance to end an abusive relationship? Yes___ No___

Have you talked with anyone about your decision to have an abortion? (Please circle)
Physician Counselor Family Friend Partner None

Who is supporting you in your decision? (Please circle)
Physician Counselor Family Friend Partner None

Is anyone with you today? **Yes No**

First Name: _____ Relationship:_____

Do you feel in any way pressured about your decision to have an abortion?
_____

If yes, please explain: _____

What doubts or fears do you have about the procedure?
_____

Reason for termination:
_____

Number of previous terminations, if any? _____

What are you most concerned about today?
_____

Is there anything else that we should know?
_____

How did you find us?
_____

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PATIENT INFORMATION

STOP HERE

To be completed by staff:

Patient's concerns addressed ( ) Staff notes / Action taken: _____

_____

Referrals for counseling given ( ) Yes ( ) No

Reviewed by: _____

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REPRODUCTIVE HISTORY

Patient Name _____

MENSTRUAL HISTORY

First Day of Last Period: _____ Was it normal? ( ) Yes ( ) No

Do you have cramping/pain with your periods? _____ Please describe: _____

CONTRACEPTIVE HISTORY

Please circle any birth control method you would like to receive information on today:

Birth Control Pills Patch Nuva Ring Condoms

Please note, birth control is only prescribed at the post check/follow-up appointment. By circling the above options, you will be given an informational pamphlet to help you make and informed choice. Current prescription options available through NFWS are birth control pills, OrthoEvra Patch and NuvaRing.

PREGNANCY HISTORY

Are you currently breast-feeding? ____ YES ____ NO

How many times, **including now**, have you been pregnant? _____ Please give the number and dates of each pregnancy:

Vaginal Deliveries: _____ Miscarriages: _____

C-Section Deliveries: _____ Reason for C-Section Deliveries: _____

Ectopic Pregnancies: _____ Stillbirth: _____

Deaths: _____ Abortions: _____ Where?_____ Was sedation used?_____

Have you had a previous problem with any pregnancy, delivery, or abortion? _____ If yes, please explain:_____

_____

Patient Signature: _____ Date signed:_____

***TO BE COMPLETED BY STAFF ONLY**

LMP:_____

Med Hx review? YES NO

Informed Consent(s)? Vacuum Aspiration: YES NO Medication: YES NO

Alternatives offered? YES NO

Decision-making discussed? YES NO Support of: _____

Desires contraception? YES NO Here_____ PMD_____ Type_____

Handouts given? YES NO

Consent signed? YES NO

Discussed need to hold still? YES NO

Advised breathing technique? YES NO

REVIEWED BY: _____

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ULTRASOUND DESCRIPTION CONSULTATION & STATE MATERIALS OFFERING

In 2011 the State of Florida made a law which requires an ultrasound before an abortion. The law also requires that the patient be offered an opportunity to view and hear an explanation of the live ultrasound images before giving informed consent. The law also allows you to decline this viewing and listening consultation process if you so choose.
In order to decline, "the woman shall complete a form acknowledging that she was offered an opportunity to view and hear the explanation of the images but that she declined the opportunity. The form must also indicate that the woman's decision was not based on any undue influence from any person to discourage her from viewing the images or hearing the explanation and that she declined of her own free will."

Please indicate your choice below.

( ) I have read the above information, understand its meaning and decline to have the viewing and listening consultation of my own free will without any undue influence from any person. I understand NFWS will complete a confirmation ultrasound but this is not considered "detailed" and I WILL NOT be charged additional fees.

Patient Signature _____

----OR----

( ) I choose to have the viewing and listening consultation. I understand that this ultrasound would be different from the confirmation ultrasound. I understand the consultation fee is $80.00 (eighty dollars).

Patient Signature _____
$80 fee collected by: _____Date:_____
Consultation done by MD _____Date:_____

Florida law, also, mandates that a patient seeking an abortion be offered the state provided material titled, "Fetal Development and Alternatives to Terminating a Pregnancy". We have no knowledge of and are not responsible for the contents of this material. I have been offered this material. My signature below indicates that I have been offered the required material. NFWS does not dictate and is not responsible for the contents of the state offered materials.

Patient Signature:_____Date:_____

Witness _____Date:_____

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INFORMED CONSENT FOR MEDICAL ABORTION

(**Not** needed for patients having the vacuum aspiration procedure.)
*Please **INITIAL** on the short line after reading each section.

_____ I, _____ have fully and honestly informed North Florida Women's Services, Inc.(NFWS), of my medical history including any history of heart, liver, kidney or bowel disorders, glaucoma or inherited porphyries. I have also disclosed **any** current medications and or drug use and reactions to medications and/or drugs.

_____ I have been informed of the risks and benefits of medication abortion versus vacuum aspiration abortion and understand the differences.

_____ I have received, read and understand the *Mifeprex (Mifepristone) Medication Guide,* and the *Facts About Mifepristone and Misoprostol Handout*. I have had an opportunity to discuss this information. I acknowledge that no assurance or guarantee has been offered to me as to the results that may be obtained.

_____ I understand that I may (rarely) experience a second episode of heavy bleeding several weeks to months after initiating medication abortion; this event is distinct from the more commonly experienced heavy first menses which may occur after either a medication or vacuum aspiration abortion.

_____ I understand that I will be administered an evidence based regimen of Mifeprex and misoprostol rather than the FDA approved regimen which advises swallowing three Mifeprex pills then returning two days later to swallow two misoprostol pills. Using the evidence based regimen I will swallow one Mifeprex pill at NFWS and will receive four misoprostol tabs to self administer at home. The National Abortion Federation reports that evidence based medication abortion causes fewer side effects, more complete expulsion, and the lower dose of Mifeprex is just as effective

_____ I understand that the medical doctor administering the medication abortion medications will provide instructions on how to self administer the misoprostol at home.

_____ I understand that a medication abortion is a relatively safe procedure but there are inherent risks and complications, which could require further medical care. I understand that if a complication does occur that requires hospitalization or continued care in a different facility, I will be responsible for any additional medical costs for such care. I realize that his would be a rare event and any additional care would be for my safety and well-being.

_____ I understand specific risks involved with medication abortion include:

- Incomplete abortion, which may require more medication and/or vacuum aspiration.
- Continued pregnancy requiring a vacuum aspiration abortion to terminate the pregnancy.
- Infection requiring antibiotic treatment and possible hospitalization.
- Excessive bleeding and dizziness requiring surgical intervention and/or blood transfusion.
- Adverse reactions to the medication abortion medications.
- Death can occur following an abortion due to infection, blood loss or unknown reasons.

_____ I understand the necessity of a follow-up evaluation to determine the completeness of the medication abortion process and agree to return on the scheduled day. I understand that it is my responsibility to see that I obtain this check-up. And, if I cannot keep the original appointment, to call and reschedule. I further understand that my failure to return for this examination and evaluation relieves NFWS, physicians, employees and agents from responsibility for possible problems or consequences that could arise as a result of my failure to return.

_____ I acknowledge that I have read, or have had read to me, and fully understand the information given to me about the process of the medication abortion, including alternative methods of treatment, risks and discomforts to be expected, and the possibility that complications from both known and unknown causes may arise as a result thereof. I voluntarily accept the risks associated with the use of medication abortion medications and wish to proceed with their use in the termination of my pregnancy.

_____ I hereby give consent to have an ultrasound and a medication abortion performed.

Print Patient Name: _____Patient Signature_____Date:_____

Witness Signature: _____

STOP – This section to be completed with MD.

In person, the Doctor and/or staff has orally informed me of the nature and risks of undergoing the procedure. I will be informed of the probable age of the fetus (if there is one), which will be verified by ultrasound, and I have been informed of the medical risks to me and a fetus, of carrying a pregnancy to term. This has been explained to me in a manner which I understand.

Patient Signature: _____ Date: _____

MD Signature: _____

Consent needs to be reviewed and resigned if: change in physician providing service, or more than 7 days since signature.

Patient Signature: _____ Date: _____

MD Signature: _____

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INFORMED CONSENT FOR VACUUM ASPIRATION ABORTION

(MUST BE FILLED OUT FOR PATIENTS CHOOSING MEDICL ABORTION AS WELL)

Patient Name:_____

Before you consent, make sure you understand the information that we have given you. If you have any questions, we will discuss them with you. Remember that your consent is entirely voluntary. If you do not want to have an abortion please let a staff member know **NOW**.

Disclosure of Alternatives, Risks and Benefits:

* Please **INITIAL** on the short line after reading each section.*

_____ I understand that the nature of an abortion procedure is to induce the termination of pregnancy.

_____ I understand that the alternative to abortion is vaginal delivery or cesarean section at the end of the pregnancy. I further understand that after choosing to give birth I may become a parent or arrange for temporary foster care or adoption. I have been given the opportunity to discuss these options based on my desire of such information.

_____The generally recognized medical risks associated with carrying the pregnancy to full term vaginal delivery or cesarean section at term include but are not limited to the following: unplanned major surgery, hemorrhage, transfusion, blood clots in legs, blood clots in the lungs, hysterectomy, major infection, cervical laceration, vaginal laceration, rectal laceration, perforation of the uterus, injury to bowel/bladder, major and minor emotional problems, amniotic fluid embolism, cervical incompetence, major and minor depression, elevated blood pressure, seizures, diabetes and even death. Only an OB/GYN involved in your personal prenatal care can discuss which of these potential risks may affect you specifically.

_____Benefits of choosing to continue pregnancy and childbirth or choosing to terminate the pregnancy are personal. They may reflect moral and/or religious beliefs with expected or unexpected physical, mental or emotional consequences.

_____ I understand that even with the most thorough medical care before, during and after the abortion, there are possible complications including:

~ Perforation of the uterus requiring surgical repair or removal of the uterus (hysterectomy).
~ Infection, which could require extended antibiotic therapy, hospitalization or surgery.
~Cervical tear which may require chemical treatment or stitches to repair.
~ Excessive bleeding which could require blood transfusion, hospitalization or surgery.
~Perforation of the bowel or bladder which would require additional surgery.
~ Blood clots which may cause severe cramping and require additional medication, or a repeat aspiration.
~Emotional discord, minor or major.
~ Incomplete termination of the pregnancy or failure to end the pregnancy which may cause excessive bleeding or infection and could require a repeat procedure in this facility or in a hospital setting. I also understand that ectopic pregnancy (a pregnancy outside the uterus), is not ended by this procedure and may require hospitalization, medication and possible surgery to remove it.
~ Asherman's Syndrome (scarring of the interior uterine wall) which could require surgical treatment and affect future fertility.
~ Inability to bear children in the future due to severe infection, hysterectomy, or Asherman's Syndrome..
~ Death can occur following elective pregnancy termination due to infection, blood loss or unknown reasons.
~ Medical problems- i.e. embolisms, anemia, depression, cardiac problems, etc.

Vacuum Aspiration Consent:

_____ I have fully and honestly informed North Florida Women's Services, Inc. (NFWS) of my medical history including surgeries, pregnancies, medication allergies, current medication and/or use of alcohol and/or street drugs.

(Continued)

INFORMED CONSENT FOR VACUUM ASPIRATION ABORTION

_____ I certify that I am not suffering from a mental, emotional or physical disability which would affect my ability to make a knowledgeable, intelligent and rationale decision to terminate my pregnancy. I am not acting under any mental or physical form of coercion in making this decision, and do so voluntarily, of my own free will and accord. I have not been coerced or otherwise influenced by any employee of NFWS regarding my decision to terminate my pregnancy.

_____ I understand that the decision to terminate my pregnancy is an emotional issue, as well as a medical one. I have been informed and understand that the termination of my pregnancy can result in an adverse psychological reaction at a later date. I do not hold NFWS, or any employee thereof, responsible for any psychological reaction resulting from the termination of pregnancy or
other treatment offered by NFWS and hereby represent and warrant that they have done nothing to create, aggravate or otherwise cause such a reaction. I further understand that professional counseling referrals are available to me at my request.

_____ I understand NFWS, has the right to refuse services to any client for whatever reason they deem appropriate.

_____ I understand that abortion by vacuum aspiration is a relatively safe procedure but there are inherent risks and complications, which could require further medical care. I understand that if a complication does occur that requires hospitalization or continued care in a different facility, I will be responsible for any additional medical costs for such care. I realize that this would be a rare event and any additional care would be for my safety and well-being.

_____ I understand that no guarantees can be made for medical procedures. In the event that a complication does occur, I authorize the doctor to do whatever is necessary to protect my health and welfare.

_____ I consent to the administration of medications as selected by the physician to assist in my comfort and safety. I realize that many adverse reactions to medications can occur including, but not limited to; allergies, stroke, heart problems, seizures, rashes, difficulty breathing, nausea and vomiting. These events can occur in an unpredictable fashion.

_____ I understand that I may request to use nitrous oxide during my abortion procedure to assist with relaxation. I understand that this is an inhalation gas that may have a possible mental transient impairment effect. I understand that this means that I should not drive or operate heavy machinery or make any important decisions requiring a judgment call until fully recovered from the effects of nitrous oxide.

_____ I understand that follow-up care is very important to assure my well-being and I agree to follow all instructions. These include: taking any prescribed medications, checking my temperature twice daily for 2 weeks and reporting elevations above 100.4F, avoiding strenuous activity for ten days, not allowing anything to enter my vagina for two weeks, and having an after care exam done. I have received written and verbal post-abortion instructions and emergency contact information. I agree to call NFWS regarding any questions or complication I may have.

_____ I consent to the performance of an ultrasound prior to my abortion procedure. I understand the purpose of this ultrasound is to date the pregnancy and not to diagnose abnormalities.

_____ I understand that tissue will be removed during the abortion and consent to the examination and disposal of such.

_____ I understand that the physician performing the procedure may not be an employee or agent of the NFWS. I further understand that the physician is engaged by NFWHCS to perform services by his/her own methods and the performance of professional services by the physician are not controlled or subject to control by NFWS.

_____ I understand that the physician performing my abortion may reside outside of Leon County and that in case of emergency my case may be transferred to a local physician.

(Continued)

INFORMED CONSENT FOR VACUUM ASPIRATION ABORTION

_____ I have received from NFWS a detailed handout about the purpose, and possible risks/complications of vacuum aspiration abortion. I understand this material, and have had the opportunity to have all questions answered.

_____ I hereby request an abortion under my fully informed consent. I am of sound mind and have fully disclosed any medical conditions, allergies, current use of any medication, alcohol or illegal street drugs. I have fully disclosed all previous surgical procedures and have truthfully answered all questions asked of me. I do understand that failing to disclose medical conditions, or history or drug use can result in serious medical or surgical complications. I am requesting an abortion of my own free will.

_____In case of emergency I authorize North Florida Women's Services, Inc., to contact the person I have named as my emergency contact.

Patient Name: _____ Patient Signature: _____
Date_____

Witness Signature: _____
Date_____

STOP – This section to be completed with MD.

In person, the Doctor and/or staff has orally informed me of the nature and risks of undergoing the procedure. I will be informed of the probable age of the fetus (if there is one), which will be verified by ultrasound, and I have been informed of the medical risks to me and a fetus, of carrying a pregnancy to term. This has been explained to me in a manner which I understand.

Patient Signature: _____ Date: _____

MD Signature: _____

Consent needs to be reviewed and resigned if: change in physician providing service, or more than 7 days since signature.

Patient Signature: _____ Date: _____

MD Signature: _____

(End) (3 of 3)

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FEE SCHEDULE

VACUUM ASPIRATION ABORTION: $475

- This procedure is completed in office up to 13 weeks and 6 days from first day of last normal period.
- Cost includes nitrous oxide gas, which is a mild sedative that helps with relaxation, local anesthetic and follow-up appointment within 6 weeks of procedure.

MEDICATION ABORTION: $515

- This procedure is initiated in the office and completed at patient's home up to 10 weeks and 3 days from first day of last normal period.
- Cost includes Mifeprex and Misoprostol to complete the medication abortion, secondary Vacuum Aspiration if needed and follow up appointment if completed within 6 weeks of procedure

BLOOD TYPING: $30

- If you have been a patient at NFWS within the last 7 years we will have your blood type on file, and you will not have to have your blood typed again.
- If you have not been a patient at NFWS before, and are able to bring in documentation of your blood type this fee is waived.
- Documentation must be from your physician, emergency room/hospital lab results, any lab results from an independent lab (such as Lab Corp or Quest), from a blood bank (such as Suncoast Blood Bank, or One Blood), or listed on a Red Cross card. Word of mouth does **NOT** count as blood type documentation, and will require you to have your blood typed here, and pay the $30 typing fee.

RHOGAM INJECTION: $50

- Rhogam injections are given ONLY to patients with **NEGATIVE** blood types. If you are a positive blood type this fee will not apply to you. Rhogam injections MUST be received here in the office same day of service.

MEDICATIONS: $5 - $50

- Motrin: $5
- Amoxicillin: $15
- Fluconazole: $10
- Metronidazole: $15
- Phenergan: $15 (For Chemical Abortion Only)
- Methergine: $25 / $20 if purchased with $30 Med Pack (antibiotics, Fluconazole, and Motrin combo)

IMPORTANT INFORMATION:

- If a patient does not qualify for a procedure at NFWS all funds, except for the non-refundable $140 fee, will be refunded to the patient.
- NFWS accepts all major credit cards, money orders or cash. To use credit cards, the person listed on the credit card *must* be present with proper identification or have sent in an authorization letter authorizing usage and the amount to be charged. The letter must also include a copy of the credit card and a copy of the person's identification
- NFWS does **NOT** accept personal checks.
- NFWS does **NOT** file any insurance claims.
- NFWS does **NOT** accept Care Credit.
- NAF (National Abortion Federation) may offer financial assistance to women that qualify; 1(800) 772-9100

I have read and understand the fees associated with my procedure. I am *aware* that all *funds* are due before a procedure will be completed.

Patient Name (printed)	Patient Signature	Date