CAMELBACK FAMILY PLANNING

Gabrielle Goodrick, MD & Associates
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Health History

Full Name (printed): _____ Date of birth: ___/___/___ Date: ___/___/___

Do you have any allergies to medication, metals, latex, rubber gloves, tape, shellfish, or antiseptic solutions (iodine/Hibiclens)?
Yes ☐ No ☐ If yes, list allergy and reaction: _____

Have you ever had a bad reaction to anesthesia or sedation?
Yes ☐ No ☐ If yes, explain: _____

Are you currently taking any medications, drugs, over-the-counter or herbal medications, vitamins, or mineral supplements?
Yes ☐ No ☐ If yes, list: _____

Past Medical History: Have you ever had any of the following:

YES	NO	
☐	☐	Heart disease, heart attack or serious heart valve problem
☐	☐	Pulmonary Embolism (PE) or Blood clotting disorders
☐	☐	Bleeding problems
☐	☐	Anemia
☐	☐	Elevated blood pressure
☐	☐	Long-term steroid medication use (e.g., prednisone)
☐	☐	Uterine abnormalities/fibroids
☐	☐	Blood transfusion
☐	☐	Genital herpes - Last outbreak ___/___/___
☐	☐	Chlamydia, gonorrhea, pelvic inflammatory disease (PID) or other STI
☐	☐	Asthma, breathing problems, other lung disease (e.g., sleep apnea)/ Inhaler use
☐	☐	Kidney disease or kidney failure or chronic adrenal failure
☐	☐	Deep vein thrombosis
☐	☐	Stroke
☐	☐	Seizures or epilepsy
☐	☐	Bowel disease (e.g., IBS, Crohn's)
☐	☐	Thyroid disease
☐	☐	Bladder Infection
☐	☐	Sickle Cell Disease
☐	☐	Anxiety or Depression
☐	☐	Cancer – If yes, what? _____
☐	☐	Serious medical problems, illness, hospitalizations, surgeries, blood transfusions or exposure to blood products – If yes, explain: _____
☐	☐	A medical problem being managed by another health care provider or any planned upcoming major surgeries – If yes, explain: _____

Social History:

YES	NO	
☐	☐	Do you smoke cigarettes/cigars or chew tobacco? If yes, how many/much do you smoke/chew a day? _____
☐	☐	Do you drink alcohol? If yes, how often and how much? _____
☐	☐	Have you ever used street or IV drugs or other substances? If Yes, list: _____

Review of Systems: Do you NOW have any of the following:

YES	NO	
☐	☐	Cardiovascular: Irregular heartbeat, severe chest pain not resolved with antacids
☐	☐	Neurological: Migraine OR an increase or change in headaches
☐	☐	Endocrine: Excessive thirst or night sweats
☐	☐	Lymph: Painful or swollen glands in your groin
☐	☐	Gastrointestinal: Ongoing nausea or severe abdominal pain, change in bowel movements
☐	☐	Chest/Breast lump, constant pain, or nipple discharge – If yes, describe: _____
☐	☐	Respiratory: Difficult breathing with exercise
☐	☐	Psychosocial: Difficulty sleeping, eating, going to work or school for greater than 3 weeks
☐	☐	Genitourinary: Pain/Burning or bleeding with urination
☐	☐	Genitourinary: Severe pain with periods that may include nausea, vomiting, or interfere with school or work
☐	☐	Genitourinary: Severe or persistent pelvic or groin pain
☐	☐	Genitourinary: Abnormal discharge – If yes, describe: _____
☐	☐	Genitourinary: Pain or bleeding with sexual activity
☐	☐	Genitourinary: Itching or irritation of genital area
☐	☐	Skin: Rashes or lesions, bumps, sores – If yes, describe: _____
☐	☐	Mouth: Bumps or sores in the mouth – If yes, describe: _____

Menstrual History (Please answer every question):

When was the first day of your last menstrual period? ____/____/____ Age that you first started your period: _____

Was your last period normal? Yes ☐ No ☐ If no, explain: _____

Do you have problems with your period? Yes ☐ No ☐ If yes, explain: _____

Have you ever had an abnormal pap smear, colposcopy, cryo or LEEP? Yes ☐ No ☐

Month/Year of last pap smear: _____/_____

Contraceptive History (Please answer every question):

Are you interested in getting birth control today? Yes ☐ No ☐ If yes, what: _____

What birth control method are you currently using? _____

Any problems with this method? Yes ☐ No ☐ If yes, explain: _____

What methods have you used in the past? _____

Any problems with your previous methods? Yes ☐ No ☐ If yes, explain: _____

Pregnancy History (Please answer every question):

Number of Pregnancies: Vaginal _____ C-Sections _____ Miscarriages _____ Abortions _____ Ectopic (tubal) ____

When did your last pregnancy end? ____/_____/____ Are you breast feeding now? Yes ☐ No ☐

Any complications? _____

Name & Phone of Medical Provider: _____

Patient signature: _____ Date: ____/_____/_____

Staff signature: _____ Date: ____/_____/_____

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Preoperative Information and Consent for Surgical Abortion

I hereby request and consent to have Gabrielle Goodrick, MD or associate perform a surgical abortion on me. I fully understand the purpose of this procedure is to terminate my pregnancy. This is my personal decision, and no one has coerced me or compelled me to make this decision. After full consideration of all my options including continuing the pregnancy and adoption, I have chosen not to continue the pregnancy.

Patient Signature: _____

Please initial next to each line below in the space provided:

_____ I have completely and accurately disclosed my medical history including any health conditions, sexually transmitted infections, known allergies and medications or drugs taken within the last forty-eight hours. I authorize the physician to make medical decisions based upon these disclosures.

_____ I consent to the taking and testing of blood samples. I understand these tests are routinely performed and are a necessary component of my care. I understand that the products of conception will be removed during the abortion and I consent to their disposal by Gabrielle Goodrick MD or associate in a manner deemed appropriate.

_____ I consent to the administration of IV Fentanyl and Versed which is intended to control pain and relax me during the procedure. If I receive this, I may experience drowsiness, fatigue, poor muscular coordination, phlebitis, unanticipated depth of sedation and partial amnesia. I also will receive a para- cervical block with lidocaine. I understand that in a small number of women severe allergic reactions, cardiovascular and respiratory compromise, shock, arrest and death may occur requiring emergency care.

_____ I understand that all forms of anesthesia involve risks and no guarantees can be offered to me regarding my treatment or its outcome. Possible risks include awareness, aspiration and depressed respiration. If I receive the narcotic and/or Versed, I understand that I must not engage in activities that require mental alertness, including driving a motor vehicle, operating machinery or making any financial or business decision for twenty-four hours.

_____ I understand these risks of office-based surgery with Conscious Sedation and would like to have my procedure done in the office. The advantages of doing this include excellent pain control, decreased cost and convenience. My other options include using only local anesthesia with or without oral pain medication and/or an oral sedative, or having my procedure done in a hospital. I do not want to have my procedure done in the hospital.

Procedure:

_____ I understand that an abortion consists of opening the cervix (the entrance of the uterus) with surgical instruments and/or other dilators and using suction and/or surgical instruments to remove the contents of the uterus. This is one of the most common and safest surgical procedures done in the United States. The actual procedure takes 5-10 minutes.

_____ I understand the procedure and I will make sure all of my questions are answered completely to my satisfaction

_____ I understand that complications with surgical abortion are uncommon but could include the following:

* 1 per 100: Laceration (tearing) of the cervix which may require medication or suturing.
* 1 per 1000: Perforation or injury to the uterus which may include damage to internal organs. Hospitalization would be required, and surgery may be necessary.
* 1 per 1000: Hemorrhage, heavy bleeding that may require evaluation of the patient and further treatment. Very rarely a blood transfusion might also be needed.
* Reaction to the anesthesia and/or medications resulting in shock, convulsions or death.

_____ I acknowledge that the complications that may occur after the procedure are the following:

* 1 per 100: Post Abortion Syndrome, trapped blood clots in the uterus that may cause severe cramping and abdominal pain. A second procedure may be required.
* Less than 1 per 500: Continuing pregnancy that may be due to multiple pregnancies, double uteri or ectopic pregnancy. A second procedure would be required, and an ectopic pregnancy may require hospitalization and treatment.
* 1 per 1000: Infection of the uterus with or without infection of the fallopian tubes and ovaries, which may require antibiotic therapy and very rarely can lead to the loss of childbearing capacity.
* Hemorrhage, heavy bleeding that may require evaluation of the patient and further treatment.
* Emotional problems. Although most women report relief, some women may experience depression or guilt following an abortion. Our staff is available to help women deal with these feeling or provide appropriate referral.

_____ I understand that I would be financially responsible for any expenses arising from complications from the abortion procedure. I understand that such complications can be caused by my own condition or conduct and through no fault of the physician. I understand that no guarantees about my future fertility can be offered to me and no such guarantees have been made to me. I will receive written discharge instructions and I understand the importance of follow- up care. I agree to call Camelback Family Planning regarding any question or complications I may have. I understand Camelback Family Planning has the right to refuse me services for whatever reason they deem appropriate.

Reviewed By Clinic Staff _____

Preoperative Information and Consent for Surgical Abortion (Cont'd)

Please initial next to each line below in the space provided:

For patients with gestation OVER 12 weeks:

____ If the doctor decides the procedure can be safely completed in one day, I will receive Misoprostol, a medication that softens and dilates the cervix. I will then wait at the office for at least 90 minutes before the procedure is done. The visit will be approximately 4-6 hours.

Certifications required by the State of Arizona:

_____ I certify that my decision to have an abortion is not based on the sex or race of the fetus, the race of the father, or my own race. I further certify that the abortion is not being financed because of the sex or race of the fetus.

_____ I waive my right to decide the disposal of the pregnancy tissue. This means you will allow our clinic to cremate the pregnancy tissue. **The clinic has always disposed of the pregnancy tissue at no extra cost.**

I brought a Driver:

____ I understand that if I receive IV Fentanyl or Versed during my visit to Camelback Family Planning, I must not drive myself home after my procedure nor engage in any activity requiring mental alertness for twenty-four hours. I have brought a driver with me and he or she will be responsible for ensuring my safe return home.

Driver's Name:	Driver's Cell:
Driver's Signature:	

OR, I failed to bring a Driver:

_____ I have failed to bring a driver to provide me a ride home. Therefore, I am arranging for a taxi to drive me home or I will drive myself home. I have been given the option to reschedule my appointment but am choosing to proceed. I understand that the physician will use her judgment to determine which medications I can receive. I can safely receive Motrin and drive home. I hereby release Dr. Goodrick or associate of any and all liability and responsibility for my safe return home after receiving any medications.

Emergency Contact (please complete, even if this is same info as the driver today):

In the event of an emergency, I authorize Gabrielle Goodrick MD or designated associate to provide emergency care using her medical judgment, including transfer to a local hospital. I understand that patient confidentiality cannot be preserved if transfer to a hospital is necessary. In the event of an emergency I authorize Gabrielle Goodrick MD or associate and designated staff to contact the following individual:

Contact Name:	Relationship:
Street Address:	City/State:
Tel/Cell:	Alternate #:

I have taken the time to think about my options concerning this pregnancy and I have decided: (Please select one)

- ☐ I am comfortable with my decision to terminate this pregnancy
- ☐ I am NOT comfortable with my decision to terminate this pregnancy

Patient Signature	**Patient Name (printed)**	**DATE**
Physician Signature	**Staff Signature**	**DATE**

Risks and complications have been verbally reviewed with the patient.

The following information is required by Arizona State law and is both confidential and anonymous.