Northeast Ohio Women's Center
(330) 923-4009
www.northeastohioabortion.com

Patient Intake

PATIENT LABEL

Are you a previous patient? Y N

Name:_____

Age:_____ **Date of Birth:**_____

Street Address:_____

_____

Phone Number:_____
Can we identify ourselves as NEO Women's Center if we need to call? Y N
Your email address_____

Emergency Contact Information
Name:_____

Phone Number:_____

First day of last menstrual period:_____

Medical or Mental Health Problems:

_____

_____

_____

Family History of Medical or Mental Health Problems:

_____

_____

Medications Now Taking:

_____

_____

Allergies:

_____

_____

Zip Code:_____ **County:**_____

Race:_____ **Marital Status:**_____

Highest Level of Education Completed:_____

Total # of pregnancies including this one _____

# of Living Children: Vaginal Delivery:_____ **C-Sect**_____

# of miscarriages:_____

# of previous abortions:_____

Date of last live birth:_____

Date of last abortion:_____

Date:_____

Have you ever had or do you have any of the following:

Diabetes	**Y**	**N**
High Blood Pressure	**Y**	**N**
Asthma	**Y**	**N**
Leg Blood Clots	**Y**	**N**
Cancer	**Y**	**N**
IUD in place now	**Y**	**N**
HIV/AIDS/Immune Disease/STDs	**Y**	**N**
Kidney or Liver Disease	**Y**	**N**
Seizures	**Y**	**N**
Acute I.B.S.	**Y**	**N**
Bleeding Disorders/Clotting Problems	**Y**	**N**
Thyroid Disease	**Y**	**N**
Currently Breastfeeding	**Y**	**N**
Anemia	**Y**	**N**
Steroid Use	**Y**	**N**
Heart Problems	**Y**	**N**

Do you smoke? **Y** **N**
How many packs per week?_____

Do you take any of the following medications: Salicylates(aspirin), Indomethacindocin, Oxytocins (methergine or ergonovine), and Antipsychotic medications **Y** **N**

Are you under a doctor's care? **Y** **N**
Have you had recent surgery? **Y** **N**
If yes, explain:

_____

_____

Birth control practiced at the time of this pregnancy:

_____

Birth control you would like to use after your procedure:

_____

BP:_____ **Pulse:**_____ **Temp:**_____

Height:_____ **Weight:**_____ **Hb:**_____