

Client Evaluation Form

Client's name _____

ID number _____ **Date** _____ **Age** _____

Abortion indication

Obstetrical history: G _____ P _____

of vaginal deliveries _____

of cesarean sections _____

Prior ectopic pregnancy? _____

Any prior pregnancy-related complications? _____

Other surgeries: _____

Allergies: _____

Medications: _____

Prior medical history:

Body System	Check (✓) if yes	Diagnosis
Respiratory (e.g. asthma)		
Cardiovascular (e.g. hypertension)		
Hepatic		
Endocrine and Metabolic (e.g. diabetes)		
Genitourinary (other than pregnancies or sterilization)		
Psychiatric		
Hematologic/Lymphatic (e.g. bleeding disorders and/or anemia)		
Other		

Physical Exam: BP _____ Pulse _____ Temp _____

Heart:	Pelvic exam:
Lungs:	Other:
Abdomen:	

Labs: Hb/Hct (not required) _____ Rh (not required) _____

Dating:

LMP _____ Uterine size _____ Fundal height _____

Positive pregnancy test and date (not required/if applicable) _____

Estimated date of quickening (if applicable) _____

Ultrasound (if available): Date _____ Gestational age _____

Today's gestational age _____

Today's Estimated Gestational Age _____**Other:**

Planned contraception _____

Rhogam needed (if applicable) ? Yes ☐ No ☐Informed consent reviewed Yes ☐ No ☐

Mifepristone 200mg po given Date _____ Time _____

Return to hospital Date _____ Time _____

Provider name (print) _____