

DEPARTMENT OF HEALTH AND SOCIAL SERVICES REPORT OF INDUCED TERMINATION OF PREGNANCY

PLEASE TYPE OR PRINT

1) PATIENT'S AGE	2) DATE OF PREGNANCY TERMINATION (MM/DD/YY) ____/____/____	3) CITY WHERE TERMINATION OF PREGANCY OCCURRED	
4) PATIENT'S ETHNICITY		5) PATIENT'S RACE	
<input type="checkbox"/> NON-HISPANIC <input type="checkbox"/> MEXICAN <input type="checkbox"/> PUERTO RICAN <input type="checkbox"/> CUBAN <input type="checkbox"/> CENTRAL OR SOUTH AMERICAN <input type="checkbox"/> OTHER OR UNKNOWN HISPANIC		<input type="checkbox"/> WHITE <input type="checkbox"/> AFRICAN AMERICAN (BLACK) <input type="checkbox"/> NATIVE ALASKAN OR AMERICAN INDIAN <input type="checkbox"/> ASIAN <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> OTHER (SPECIFY) _____	
		6) CITY AND STATE WHERE PATIENT RESIDES	
		7) MARRIED <input type="checkbox"/> YES <input type="checkbox"/> NO	
		8) EDUCATION (SPECIFY THE HIGHEST GRADE COMPLETED)	
		ELEMENTARY/SECONDARY (0-12)	COLLEGE (1-4 OR 5+)
PREVIOUS PREGNANCIES (COMPLETE EACH SECTION. DO NOT LEAVE BLANK.)			
9) NUMBER OF PREVIOUS LIVE BIRTHS		10) NUMBER OF PREVIOUS SPONTANEOUS ABORTIONS	
9A) NOW LIVING		NUMBER _____ <input type="checkbox"/> NONE	
NUMBER _____			
9B) NOW DEAD		11) NUMBER OF PREVIOUS INDUCED TERMINATIONS OF PREGNANCIES (DO NOT INCLUDE THIS TERMINATION)	
NUMBER _____		NUMBER _____ <input type="checkbox"/> NONE	
12) PHYSICIAN'S ESTIMATE OF GESTATION		13) DATE LAST NORMAL MENSES BEGAN (MM/DD/YY)	
COMPLETED WEEKS _____		____/____/____	
		14) METHOD OF PAYMENT	
		<input type="checkbox"/> MEDICAID <input type="checkbox"/> INSURANCE <input type="checkbox"/> OTHER (SPECIFY) _____	
15) PRIMARY PROCEDURE USED TO TERMINATE PREGNANCY (CHECK ONE ONLY)		16) WAS THIS TERMINATION ELECTED DUE TO THE DETECTION OF A CONGENITAL ANOMALY?	
15A) <input type="checkbox"/> SUCTION CURETTAGE 15B) <input type="checkbox"/> DILATION AND EVACUATION 15C) <input type="checkbox"/> SHARP CURETTAGE 15D) <input type="checkbox"/> SALINE 15E) <input type="checkbox"/> PROSTAGLANDIN 15F) <input type="checkbox"/> HYSTERECTOMY 15G) <input type="checkbox"/> HYSTEROTOMY 15H) <input type="checkbox"/> MIFEPRISTONE 15I) <input type="checkbox"/> METHOTREXATE 15J) <input type="checkbox"/> OTHER (SPECIFY) _____		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		16B) TYPE OF CONGENITAL ANOMALY	
		CHROMOSOMAL ANOMALY YES <input type="checkbox"/> NO <input type="checkbox"/> NEURAL TUBE DEFECT YES <input type="checkbox"/> NO <input type="checkbox"/> HEART ANOMALY YES <input type="checkbox"/> NO <input type="checkbox"/> VENTRAL WALL DEFECT YES <input type="checkbox"/> NO <input type="checkbox"/> OTHER YES <input type="checkbox"/> NO <input type="checkbox"/> (SPECIFY) _____	
<input type="checkbox"/> YES <input type="checkbox"/> NO PATIENT REQUESTED A COPY OF THE INFORMATION REQUIRED TO BE MAINTAINED ON THE INTERNET UNDER AS 18.05.032			
<input type="checkbox"/> YES <input type="checkbox"/> NO PATIENT RECEIVED A WRITTEN COPY OF THE INFORMATION REQUIRED TO BE MAINTAINED ON THE INTERNET UNDER AS 18.05.032			