HOUSTON WOMEN'S CLINIC MEDICAL HISTORY FORM

This questionnaire is part of your medical record and is used by the staff to anticipate any problems you might have relating to the abortion. This record is strictly confidential.

Name _____ Address _____

City/State _____ County/Zip _____

Birthdate _____ Age _____ Marital Status _____

Telephone _____ Work phone _____

Occupation _____ Education _____

Were you using birth control when you became pregnant?_____

When was the first day of your last normal period? _____

How often do your periods occur? _____At what age did your periods begin?_____

Would you describe your periods as: Heavy _____
Moderate _____
Light _____

At what age did you become sexually active? _____

Please indicate the types of birth control you have used and give length of time you used each one:

Birth control pills	_____	Withdrawal	_____	Rhythm	_____
Condoms/Spernicide	_____	Abstinence	_____	IUD	_____
Depo-provera	_____	Diaphragm	_____	Other	_____

Not counting this pregnancy, how many times have you been pregnant? _____

Please indicate number of:

_____	_____	_____	_____	_____	_____	_____
Live birth	Miscarriages	C-Sections	Abortions	D&C	Ectopic pregnancies	Living children

Date of last abortion _____last miscarriage _____birth of youngest child _____

Did you have any complications. especially problems with bleeding, with, previous abortions, pregnancies or miscarriages? _____ If yes, explain:
_____

Have you ever been seriously ill? (e g., heart disease, kidney disease, kidney disease, hepatitis, mental illness, etc.) _____ Please explain: _____

What surgical procedures have you had?

_____

Have you even been treated for asthma? _____

Are you allergic to any drugs or medications? _____ If yes; which ones?

_____

_____

Are you taking any drugs or medications now? _____ If yes, which ones?

_____

Have you ever fainted? _____ If yes, please explain: _____

Have you ever had a STD? _____ If yes, when and how treated?

_____

Have you ever been hospitalized overnight? _____ If yes, explain:

_____

Have you ever had a blood transfusion? _____ If yes, when and how many? _____

What factors were most important in your decision to have an abortion?

_____

When you first learned that you were pregnant, what were your thoughts and feelings about it?

_____

Did you try any other abortion methods before coming here? _____ Please explain:

_____

Do you have a doctor who knows about the abortion? _____

Personal doctor's name and address: _____

Has anyone escorted you here today? _____ Relationship _____

Do you have health insurance coverage? _____ If yes, name of carrier: _____

COUNSELOR NOTES

_____

_____

_____

_____

_____

_____

_____

_____

NAME:_____ DATE:_____

HOW DID YOU HEAR ABOUT HOUSTON WOMEN'S CLINIC? (Check all that apply)

____ friend/family referral

____ been a patient before

____ looked in the phone book (which area or city)

_____

____ clinic referral (please list the name & location)

_____

____ website/internet

____ insurance referral

____ other _____

____ doctor referral (please list name & location)

_____

If a doctor referred you, with your permission, we would like to send a letter to notify your doctor that we took care of you today. Please sign below to authorize the release of this information.

Patient Signature _____

24 Hour Certification

Name:_____Date/ time (Sono/Dr Cns) _____

The following information was presented at least 24 hours prior to the abortion by
[ ] Bernard Rosenfeld, M.D. or [ ] Yuri Nosaville, M.D.

____ the particular medical risks associated with the particular abortion procedure to be employed; including when medically accurate:
____ the risk of infection and hemorrhage;
____ the potential danger to subsequent pregnancy and of infertility; and
____ the possibility of increased risk of breast cancer following an induced abortion

____ the probable gestational age of the fetus at the time the abortion is to be performed
____ the medical risks associated with carrying the pregnancy to term.

Dr Sign:_____

The physician or the physician's agent has informed me that:

____ medical assistance benefits may be available for prenatal care, childbirth and neo-natal care;
____ the father is liable for assistance in the support of the child without regard to whether the father has offered to pay for the abortion;
____ public and private agencies provide pregnancy prevention, counseling and medical referrals for obtaining pregnancy prevention medications or devices.
____ I have the right to review the printed materials prepared by the Texas Department of Health entitled "A Woman's Right to Know" booklet and the resource directory which describes fetal development and list agencies that offer alternatives to abortion and that those materials must be given to me if I choose to view them.
____ "A Woman's Right to Know" booklet and resource directory are also available on an Internet website sponsored by the department.

Dr or Agent Sign : _____

I made the following choice **(initial one):**

____ I requested and was provided a printed copy of "A Woman's Right to Know" booklet and resource directory

____ I chose to review "A Woman's Right to Know" materials on the website

____ I declined the informational materials

Patient signature:_____Date_____

Houston Women's Clinic

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare operations.

I understand that as part of my healthcare, this facility creates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as a:

- basis for planning my care and treatment
- means of communication among the health professionals who contribute to my care
- source of information for applying my diagnosis and surgical information to my bill
- means by which a third party payor (insurance) can verify that services billed wereactually provided
- tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have received a copy of Notice of Privacy Practices that contains a more complete description of information uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand this facility can change their notice and practice and I may request a copy of any revised notice. I understand that I can restrict how my health information may be used. I understand that I can revoke this consent in writing, except to the extent that the organization has already taken.

I request the following restrictions to the use or disclosure of my health information.

_____

Signature of Patient :_____ Date notice effective:_____

Houston Women's Clinic

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how your medical information can be used and disclosed and how you can get access to this information. Please review it carefully.

Houston Women's Clinic is committed to protecting the privacy of your medical records and the confidentiality of your visit. Your records (chart) will not be released to anyone outside of this facility with out your written permission unless a release is required by law.

We will use your information for the following purposes:

1. Treatment- to determine your care and treatment
2. Payment- if using insurance we will release information necessary for billing
3. Regular Healthcare Operations- members of the staff may review your records as part of our quality assurance
4. Business Associates- if a billing/collection service is used (we do not use any such service at this time).

Disclosure required by law:

1. Food and Drug Administration (FDA)- if there were a drug/product recall or defect
2. Public Health- we may disclose your health information, to public health authorities in charge of controlling disease, injury or disability.
3. Law Enforcement- we may disclose health information in response to a valid subpoena.

YOUR HEALTH INFORMATION RIGHTS

Your health record is the physical property of the clinic but the information belongs to you and you have the right to the following:

1. Request a restriction on certain uses and disclosures of your information
2. Obtain a copy of the notice of information practices (this document)
3. Inspect a copy of your health records
4. Amend your health record as provided in 45 CFR 164.528
5. Obtain an accounting of disclosures of your health information
6. Request communication of your health information by alternative means or at alternative locations
7. Revoke your authorization to use or disclose health information except for action already taken.

OUR RESPONSIBILITY

We are required to:

1. Maintain the privacy of your information
2. Provide you with a notice that explains our legal duties and privacy practices
3. Abide by the terms of this notice
4. Notify you if we are unable to agree to a restriction that you request
5. Accommodate reasonable requests you may have to communicate health information by

alternative means or locations.

We reserve the right to change practices and make new provisions.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

For questions or problems, our privacy officer is Bernard Rosenfeld, M.D. at 713-868-4483. Complaints may also be filed with the Secretary of Health and Human Services, with no retaliation.

I have read this privacy notice and have been given time for questions.

I understand Houston Women's Clinic will not release my health information unless I give written permission or when required by law.

_____ _____

Signature Date

Notice effective date 04-14-03

HOUSTON WOMEN'S CLINIC

INFORMED CONSENT TO TREATMENT, ANESTHETIC, AND OTHER MEDICAL SERVICES

Patient Name: _____

Date: _____

1. *I, _____, am _____ years old, and request and consent to the performance upon me of a pregnancy termination procedure by vacuum aspiration at Houston Women's Clinic by Dr. Bernard Rosenfeld, or a designated associate physician.*

2. *I further consent to the taking of cultures and the performance of reasonable indicated tests and procedures in addition to pregnancy termination, whether or not relating to presently known conditions, if my medical attendants find these necessary or advisable in the course of evaluation or treatment, for management of complications or otherwise.*

3. *I have fully and completely disclosed my medical history, including allergies, blood conditions, prior medications, or drugs taken, and reactions I have had to anesthetics, medicines, or drugs. I consent to my physicians' relying on this disclosure as complete.*

4. *I consent to the administration of such anesthesia as may be deemed necessary or advisable by my physician or associates.*

   I understand that local anesthetics do not always eliminate all pain, that in a small number of cases locals cause severe reactions or even shock and that no guarantees to the contrary have been made to me. (Or) I understand that general anesthesia will render me unconscious and may, in a small number of cases, cause bodily reactions or complications requiring additional measures and treatment, which I request and to which I consent.

5. *The first day of my last menstrual period was: _____.*
   This period was (check one): normal _____ heavy _____ light _____
   The period before it was: normal _____ heavy _____ light _____
   My periods in the past six months have been: regular _____ irregular _____ other _____
   If "other," describe: _____
   I understand that information concerning my last period is important to diagnosis and method of treatment, and I consent to treatment based upon my recollection as stated above, or upon findings from examination.

6. *I understand that tissue and parts will be removed during the procedure, and I consent to their disposal or use by the clinic and/or physician in the manner they deem appropriate.*

7. *I fully understand that the purpose of the procedure is to terminate this pregnancy. I affirm this to be my personal choice in light of the alternative of continuing the pregnancy to term. No one has coerced or compelled me to make this decision.*

8. *I understand that any questions I have will be answered by the physician and/or counselor and I agree to ask any questions before I leave the clinic.*

9. *I understand that the complications associated with pregnancy termination are generally much less severe than with childbirth. Nonetheless, I realize there are inherent risks of minor and major complications which may occur in this, as in all surgical procedures, without the fault of the physician. No guarantees have been made to me. I understand the possibility of perforation of the uterus and internal injuries resulting therefrom. I understand the possibility that not all of the tissue will be removed, that the pregnancy may not be terminated, that fever may occur, that bleeding may occur during or after the procedure, that infection may occur, that I may react badly to medicines or the anesthetic, that I may have pain, cramps or even convulsions, and that I may also have mild or severe reactions to any contraceptives which I use later. I further realize that I may need to be hospitalized at my own expense for treatment of such complications. I realize that such complications can be caused by my own condition or conduct, or by the treatment of a follow-up physician.*

10. *I understand that clinic policy dictates that I MUST NOT DRIVE A VEHICLE when I am discharged from the clinic, and I have made arrangements for another person to be responsible for my transportation. I agree that the results of non-compliance with this requirement will not be the responsibility of the clinic or its physicians.*

11. *If I have questions or complications after leaving, I agree to call the physician or clinic at (713) 868-4483 immediately. I have been advised to come in for a free follow-up examination. I understand that it is my responsibility to arrange this appointment.*

12. *I agree to make no claims against the physician or clinic for complications which may occur, except in the event of gross negligence on their part. If I should make any other claims, I agree to be responsible for the payment of all costs and attorney's fees incurred by the physician and/or clinic in investigating or defending the claims and to post a bond in advance for such sums.*

13. *I further understand that the medical practice of my physician is to be judged according to those standards reasonably acceptable to other physicians practicing in similar facilities in the United States.*

I certify that I have read and fully understand the above informed consent and that I agree in light of that consent to the pregnancy termination procedure I have requested.

Dated _____ _____
(Signature of Patient)

_____ _____
(Witness/Counselor) *(Signature of Parent if applicable)*

PARENTAL CONSENT TO ABORTION

I, _____, *the undersigned, state I am the* _____
(Name of parent) *(Father/Mother)*

of _____, *a minor.*
(Name of Patient)

I have read and signed the informed consent document required by Houston Women's Clinic.
I have been fully informed of the hazards and possible consequences involved in an abortion.
I hereby consent to such treatment for such minor by Houston Women's Clinic.

_____ _____
(Witness/Counselor) *(Signature of Parent)*

24-Hour Answering Service 713-868-4483

HOUSTON WOMEN'S CLINIC
POST-OPERATIVE INSTRUCTIONS

For the next day or two, any strenuous activity should be avoided. However, normal daily activities such as work or school can be resumed tomorrow. Should any problems or questions arise, please do not hesitate to call us at 713-868-4483 or 1-800-646-4483. Clinic hours are 8:00 AM to 5:00 pm. After hours, our answering service will take your call.

Medications

- You will be given an antibiotic to take in recovery room.
- You will be given a pain medication – take as directed.
- Birth control pills can be started the Sunday after the procedure. You will not be protected until your second pack of pills.

Cramping

It is not unusual to experience some cramping for the first week or two after the abortion. It should be similar to menstrual cramps and the medication should relieve it.

Bleeding

It should not be heavier than your typical period. Some women do not bleed at all while others have on and off bleeding for 1-2 weeks. Your next normal period should be 4-8 weeks later. It is possible to become pregnant immediately following the procedure.

Restrictions for 3 weeks

No tampon – use sanitary pads only
No intercourse or douching
No swimming

You must see us or your own physician for a 3-week follow-up exam. We are not responsible for complications of patients who have not had a follow-up.

Contact Us if:

Bleeding is heavier than your heaviest period, or soaking 1 pad in an hour
Temperature of 100.4 or higher
Severe pain or cramps not relieved by your pain medication

If you contact us after hours, we will make every reasonable effort to return your call within 30 minutes. Please stay near your phone. A nurse will handle your call.

We recommend that you contact us, but we want you to be fully aware that a hospital emergency room is always an option. If you have no insurance, you may go to Ben Taub or LBJ Hospitals. If you have insurance, you may go to Women's or S.W. Memorial Hospital.

Received Copy_____ 5/07

HOUSTON WOMEN'S CLINIC

Discussion with a staff member has addressed the following information. I have had my questions and concerns answered by the staff of Houston Women's Clinic, Inc.

Initial to indicate you understand each of the following:

_____ 1. It is my decision to terminate this pregnancy. No one is forcing or pressuring me to do this

_____ 2. I understand I have options for this pregnancy, including taking more time to consider my decision

_____ 3. Review of my personal medical history

_____ 4. Explanation of the pregnancy termination procedure, including possible risks

_____ 5. Risks involved with termination

_____ 6. Instructions for after care and medications

_____ 7. Birth control information

_____ 8. Possibility of declining of fertility after age 30

_____ 9. Need for a follow-up examination

_____ 10. I received information regarding filing a complaint against the clinic

_____ 11. Due to the sedation I will receive, I have been advised not to drive or operate equipment after the abortion

Summary of possible complications

_____ 1. Infection

_____ 2. Failure to remove all products of conception

_____ 3. Cervical incompetence

_____ 4. Asherman's syndrome

_____ 5. Perforation of the uterus

_____ 6. Injury to the bowel and/or bladder

_____ 7. Abdominal incision and operation to correct injury

_____ 8. Hemorrhage/heavy bleeding that may require a hysterectomy to control

_____ 9. Sterility

_____ 10. I understand that complications with this surgery as well as any other surgery may include death

Signature: _____ Date: _____