# 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**

- ☐ NON-HISPANIC
- ☐ MEXICAN
- ☐ PUERTO RICAN
- ☐ CUBAN
- ☐ CENTRAL OR SOUTH AMERICAN
- ☐ OTHER OR UNKNOWN HISPANIC

**5) PATIENT'S RACE**

- ☐ WHITE
- ☐ AFRICAN AMERICAN (BLACK)
- ☐ NATIVE ALASKAN OR AMERICAN INDIAN
- ☐ ASIAN
- ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- ☐ OTHER (SPECIFY) _____

**6) CITY AND STATE WHERE PATIENT RESIDES**

**7) MARRIED**

- ☐ YES
- ☐ 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**

**9A) NOW LIVING**

NUMBER _____

☐ NONE

**9B) NOW DEAD**

NUMBER _____

☐ NONE

**10) NUMBER OF PREVIOUS SPONTANEOUS ABORTIONS**

NUMBER _____ ☐ NONE

**11) NUMBER OF PREVIOUS INDUCED TERMINATIONS OF PREGNANCIES** (DO NOT INCLUDE THIS TERMINATION)

NUMBER _____ ☐ NONE

**12) PHYSICIAN'S ESTIMATE OF GESTATION**

COMPLETED WEEKS _____

**13) DATE LAST NORMAL MENSES BEGAN** (MM/DD/YY)

_____/_____/_____

**14) METHOD OF PAYMENT**

- ☐ MEDICAID
- ☐ INSURANCE
- ☐ OTHER (SPECIFY) _____

**15) PRIMARY PROCEDURE USED TO TERMINATE PREGNANCY** (CHECK **ONE** ONLY)

- 15A) ☐ SUCTION CURETTAGE
- 15B) ☐ DILATION AND EVACUATION
- 15C) ☐ SHARP CURETTAGE
- 15D) ☐ SALINE
- 15E) ☐ PROSTAGLANDIN
- 15F) ☐ HYSTERECTOMY
- 15G) ☐ HYSTEROTOMY
- 15H) ☐ MIFEPRISTONE
- 15I) ☐ METHOTREXATE
- 15J) ☐ OTHER (SPECIFY) _____

**16) WAS THIS TERMINATION ELECTED DUE TO THE DETECTION OF A CONGENITAL ANOMALY**?

YES ☐ NO ☐

**16B) TYPE OF CONGENITAL ANOMALY**

| | | |
|---|---|---|
| CHROMOSOMAL ANOMALY | YES ☐ | NO ☐ |
| NEURAL TUBE DEFECT | YES ☐ | NO ☐ |
| HEART ANOMALY | YES ☐ | NO ☐ |
| VENTRAL WALL DEFECT | YES ☐ | NO ☐ |
| OTHER | YES ☐ | NO ☐ |

(SPECIFY) _____

☐ YES ☐ NO PATIENT REQUESTED A COPY OF THE INFORMATION REQUIRED TO BE MAINTAINED ON THE INTERNET UNDER AS 18.05.032

☐ YES ☐ NO PATIENT RECEIVED A WRITTEN COPY OF THE INFORMATION REQUIRED TO BE MAINTAINED ON THE INTERNET UNDER AS 18.05.032