OREGON DEPARTMENT OF HUMAN SERVICES
Center for Health Statistics
REPORT OF INDUCED TERMINATION OF PREGNANCY

136-
State File Number

1. NAME OF FACILITY _____ FACILITY CHART OR CASE NO. _____
2. FACILITY ADDRESS _____ (CITY OR TOWN) (COUNTY)
3. DATE TERMINATION PERFORMED: _____ (MONTH) (DAY) (YEAR)
4. PATIENT'S USUAL RESIDENCE _____ (STATE) (COUNTY) (CITY OR TOWN) (ZIP CODE) (INSIDE CITY LIMITS – YES, NO)
5. AGE LAST BIRTHDAY
6. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Now Married 3 ☐ Widowed 4 ☐ Divorced 5 ☐ Separated 6 ☐ Unknown
7. IS PATIENT OF HISPANIC ORIGIN? 0 ☐ NO ☐ YES, specify Cuban, Mexican, Puerto Rican, etc. _____
8. RACE (select one or more): 1 ☐ White 2 ☐ Black 3 ☐ American Indian 4 ☐ Chinese 5 ☐ Japanese 6 ☐ Hawaiian 8 ☐ Filipino 0 ☐ Other Asian ☐ Other (specify) _____
9. EDUCATION (Indicate a NUMBER for the HIGHEST grade COMPLETED): ➜

None (0)	Elementary/Secondary (1-12)	College (1-4, 5+)

10. PREVIOUS PREGNANCIES (Complete all four sections; enter number or check None)

Live Births		Other Terminations	
a. Now Living Number _____ None 00 ☐	b. Now Dead Number _____ None 00 ☐	c. Spontaneous Abortions, Miscarriages, Stillbirths, and Fetal Deaths Number _____ None 00 ☐	d. Induced Abortions (Do not include this termination) Number _____ None 00 ☐

11. DATE LAST NORMAL MENSES BEGAN Month Day Year
12. CLINICAL ESTIMATE OF GESTATION _____ Completed weeks
13. WAS PREGNANCY THE RESULT OF A CONTRACEPTIVE FAILURE? 1 ☐ NO 2 ☐ YES If Yes, specify method below.
1 ☐ Birth Control Pill 2 ☐ Foam 3 ☐ Hormone Implant e.g. Norplant 4 ☐ Diaphram 5 ☐ IUD
6 ☐ Condoms, Prophylactics 7 ☐ Rhythm 8 ☐ Other, specify _____ 9 ☐ Contraceptive Injection e.g. Depo Provera
14. PROCEDURE THAT TERMINATED THIS PREGNANCY (Check only one)
1 ☐ Suction Curettage 2 ☐ Medical (nonsurgical) specify medication(s) _____ 3 ☐ Dilation and Evacuation (D & E)
4 ☐ Intra-Uterine Instillation (saline/prostaglandin) 5 ☐ Vaginal Prostaglandin 6 ☐ Sharp Curettage (D & C)
7 ☐ Hysterotomy/Hysterectomy 8 ☐ Other (specify) _____
15. OTHER PROCEDURES USED FOR THIS TERMINATION (Check all that apply)
0 ☐ None 1 ☐ Suction Curettage 2 ☐ Medical (nonsurgical) specify medication(s) _____
3 ☐ Dilation and Evacuation (D & E) 4 ☐ Intra-Uterine Instillation (saline or prostaglandin) 5 ☐ Vaginal Prostaglandin
6 ☐ Sharp Curettage (D & C) 8 ☐ Other (specify) _____
16. WAS WRITTEN POST-OPERATIVE/AFTER-CARE INFORMATION GIVEN TO PATIENT? 1 ☐ YES 2 ☐ NO
17. WAS FOLLOW-UP VISIT RECOMMENDED? 1 ☐ YES 2 ☐ NO
18. COMPLICATIONS **AT TIME OF PROCEDURE** (check all that apply):
0 ☐ None 1 ☐ Hemorrhage 2 ☐ Infection 3 ☐ Uterine perforation 4 ☐ Cervical laceration
5 ☐ Retained products 6 ☐ Failure of first method 7 ☐ Other (specify) _____
19. AT THE TIME OF COMPLETION OF THIS REPORT FORM HAD A FOLLOW UP VISIT OCCURRED **AT THIS FACILITY**?
2 ☐ NO 1 ☐ YES, If yes, specify complications (check all that apply):
0 ☐ None 1 ☐ Hemorrhage 2 ☐ Infection 3 ☐ Uterine perforation 4 ☐ Cervical laceration
5 ☐ Retained products 6 ☐ Failure of first method 7 ☐ Other (specify) _____
20. AT THE TIME OF COMPLETION OF THIS REPORT FORM HAD A FOLLOW UP VISIT OCCURRED **OUTSIDE THIS FACILITY**?
2 ☐ NO 1 ☐ YES 3 ☐ UNKNOWN
If yes, specify complications (check all that apply) & complete item 20a below:
0 ☐ None 1 ☐ Hemorrhage 2 ☐ Infection 3 ☐ Uterine perforation 4 ☐ Cervical laceration
5 ☐ Retained products 6 ☐ Failure of first method 7 ☐ Other (specify) _____ 9 ☐ Unknown
20A. If yes, specify location of follow up visit:
1 ☐ Physicians Office 2 ☐ Clinic 3 ☐ Hospital 4 ☐ OTHER, SPECIFY _____

PLEASE COMPLETE THIS FORM NO SOONER THAN 2 WEEKS FOLLOWING THE DATE OF TERMINATION. FORM MUST BE COMPLETED NO LATER THAN 30 DAYS FOLLOWING THE DATE OF TERMINATION OF PREGNANCY.

MAIL TO: Center for Health Statistics
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