OREGON DEPARTMENT OF HUMAN SERVICES
Center for Health Statistics
REPORT OF INDUCED TERMINATION OF PREGNANCY 136-

1. NAME OF FACILITY _____ FACILITY CHART OR CASE NO. _____

2. FACILITY ADDRESS _____ 3. DATE TERMINATION PERFORMED: _____
(CITY OR TOWN) (COUNTY) (MONTH) (DAY) (YEAR)

4. PATIENT'S USUAL OCCUPATION _____
(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) 6 ☐ 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 ☐ Physician's 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
OREGON DEPARTMENT OF HUMAN SERVICES
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