

OREGON DEPARTMENT OF HUMAN RESOURCES  
HEALTH DIVISION  
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 3.  Widowed 5.  Separated  
2.  Now Married 4.  Divorced 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 <input type="checkbox"/>	b. Now Dead Number _____ None 00 <input type="checkbox"/>	c. Spontaneous Abortions, Miscarriages, Stillbirths, and Fetal Deaths Number _____ None 00 <input type="checkbox"/>	d. Induced Abortions (Do not include this termination) Number _____ None 00 <input type="checkbox"/>

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  Diaphragm  IUD  
6.  Condoms, Prophylactics 7.  Rhythm 8.  Other, specify \_\_\_\_\_  Contraceptive Injection e.g. Depo Provera

14. PROCEDURE THAT TERMINATED THIS PREGNANCY (Check all that apply)

1.  Suction Curettage 2.  Medical (nonsurgical) specify medication(s) \_\_\_\_\_ 3.  Dilation and Evacuation (D & E)  
4.  Intra-Uterine Instillation (saline/prostaglandin)  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  Suction Curettage  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  
OREGON HEALTH DIVISION  
P.O. Box 14050  
Portland, Oregon 97293-0050