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
2. FACILITY ADDRESS (CITY OR TOWN) (COUNTY)
FACILITY CHART OR CASE NO.
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 7. ☐ Filipino 9. ☐ 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. ☐ Diaphragm 5. ☐ 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) 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:
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