Capital Region
WOMEN'S CARE
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Patient Name _____ Patient Date of Birth_____

Patient Account # _____ Date of Service_____

# Pregnancy	Date	Wk Gestation	Anesthesia	Baby Wgt	Sex	Hours Labor	Type Delivery	Doctor	Hosp.	Complications

MEDICATIONS: (List any medications taken since last menstrual period)

Name				Dose				Reason		

HOSPITALIZATIONS:

Surgery / hospitalization	Year

Your Birth weight_____

ALLERGIES

Type									Reaction