Capital Women's Care Obstetrics & Gynecology

6569 North Charles Street
Physicians Pavilion West
Baltimore MD, 21204
P.410.938.8960 F. 410.583.9770

Name:_____ **DOB**:_____ **Today's Date**: _____

Gender Identity/Pronoun Preference (please circle): Female Male Non-Binary She He Them

Sexual Preferences (Who do you prefer to have sex with): Men Women Everyone Asexual Abstinent

Sexually Active: Yes No Never

Current Contraceptive: None Vasectomy Tubal Ligation IUD Ring Depo Nexplanon
Pills Seeking Pregnancy Condoms Patch

Age of First Menses: _____ **Last Menstrual Period**: _____

Age of Menopause/ Hysterectomy: _____

Are you using Hormone Replacement: Yes No **If Yes, What are you Using**: _____

Last PAP Smear: _____ **History of Abnormal**: Yes No **If Yes, Date**: _____

Last Mamogram: _____ **Do you Smoke**: Yes No

Pregnancy History (Example: Full Term: 2 Abortions: 2) or circle: Never Pregnant

Full Term : _____ Pre Term: _____ Miscarriages: _____ Abortions: _____

Pregnancy Details:

Delivery Date: _____ **Baby's Sex**: Male Female NA **Delivery Type**: Vaginal C/S Abortion Miscarriage

Complications: _____

Delivery Date: _____ **Baby's Sex**: Male Female NA **Delivery Type**: Vaginal C/S Abortion Miscarriage

Complications: _____

Delivery Date: _____ **Baby's Sex**: Male Female NA **Delivery Type**: Vaginal C/S Abortion Miscarriage

Complications: _____

Delivery Date: _____ **Baby's Sex**: Male Female NA **Delivery Type**: Vaginal C/S Abortion Miscarriage

Complications: _____

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Medical History: (Example: Diabetes 1/2005)

Diagnosis _____ Date _____ Diagnosis _____ Date _____

Diagnosis _____ Date _____ Diagnosis _____ Date _____

Diagnosis _____ Date _____ Diagnosis _____ Date _____

Surgical History: (Example: Tonsillectomy 1/2010)

Surgery _____ Date _____ Surgery _____ Date _____

Surgery _____ Date _____ Surgery _____ Date _____

Surgery _____ Date _____ Surgery _____ Date _____

Family History: (Example: Maternal Grandmother- Diabetes) _____

_____

_____

_____

Occupation: _____

Medication Allergies and Reaction: _____

_____

List all Prescription Medications Please: _____

_____

_____

_____

Please be specific with your Pharmacy information so we may locate the correct one for you-

Preferred Pharmacy: _____

Pharmacy Address and Phone Number: _____

_____

Is there anything you want us to know? Or anything you want to add that is not already covered?

_____

_____

_____