Orrego Center for Women's Health, LLC

John Orrego, MD **Carolyn DeWalden, PA-C**

Name: _____ **Date**: _____/_____/_____

Past Health History

Please list Medical Illnesses:
1. _____
2. _____
3. _____

P lease list any prior Surgeries and dates:
1. _____
2. _____
3. _____

Tubal Ligation Yes [ ] No [ ]

LMP: _____definite / not sure

Please list medications, their dosages, and any over the counter supplements you are taking:

_____ _____
_____ _____
_____ _____

OB/GYN \History (Check those that apply)

Got pregnant while on birth control: Pill [ ] Patch [ ] Ring [ ] Depo [ ] IUD [ ] Condoms [ ]
Are your cycles regular? Yes[ ] No[ ]
Number of Sexual Partners? _____now, _____life
I Prefer to have Sex with: Opposite Sex____, Same Sex____, Both____
Total # of Pregnancies: _____ Vaginal: _____ C/Sections: _____ Miscarriages: _____ Abortions: _____
Significant history from previous pregnancies: _____
_____

Date of last Pap smear: _____/_____/_____ Allergies: _____

Family History (Check those that apply and state which relative has/had the problem)

Illness	*Which Relative*		*Illness*	*Which Relative*	
Mental Retardation	____	_____	Stroke	____	_____
Down Syndrome	____	_____	Heart attack	____	_____
Anemia	____	_____	Diabetes	____	_____
Neural tube defects	____	_____	High blood pressure	____	_____

Social History

Smoking: [ ] NO [ ]Yes: Packs/day_____ How many years? _____
Alcohol: [ ] NO [ ]Yes: Drinks/day_____ Drinks/Week Type of drink? _____
Drug Use [ ] NO [ ]Yes: What Drugs? _____
Regular Exercise: [ ] NO [ ]Yes: Which type: _____

History of spouse abuse: [ ]Yes [ ]NO

Marital Status: [ ] Married [ ] Single [ ] Divorce [ ] Widow [ ] Living together
School completed: [ ] High School [ ] College [ ] Graduate [ ] Other _____
Current or most recent job: _____

My Primary Care Physician is: _____

The Pharmacy that I usually use is: _____ Phone: _____

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