



New Patient Information

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Patient Name: _____

**PLEASE ANSWER THE FOLLOWING TO AID US IN
COMPLETING OUR RECORDS AND BETTER SERVING YOU.**

Please indicate how you learned about our practice:

Friend/Family _____ Doctor _____ Yellow Pages _____ Area Phone Book _____

Number of children _____ Number of pregnancies _____

Children's ages and birth weights _____

Did you have any cesarean births? Yes ___ No ___ Your height ___ Your weight ___

Age of onset of menstrual period? _____ Date of last menstrual period? _____

Are your periods regular? Yes ___ No ___ What do you use for birth control? _____

Do you take any birth control pills or hormones? Yes ___ No ___

If yes, please list: _____

When did you last have a pap test _____ mammogram _____ colon test _____

bone mineral density test _____

Have you ever had an abnormal pap test? Yes ___ No ___

List any allergies to medicines or latex _____

List any medicines you take _____

List any recent tests you have had _____

What is your chief complaint or reason for this visit? _____
