



The Pavilion at Doylestown Hospital
599 W State Street
Suite 301
Doylestown Pa 18901
215 489-2066

NEW PATIENT QUESTIONNAIRE

Welcome! We are glad to have you join our practice. Please complete the following questionnaire to help us provide you with the best care possible.

Name: _____

Age: _____ **Home Phone** _____ **Cell** _____

Date of Birth: ____/____/____

Emergency contact & Phone: _____

Email Address: _____

Primary Physician: _____

Pharmacy Name and Number: _____

How were you referred to our practice? _____

Reason for visit? _____

Drug Allergies: _____

Current Medications and Dosages: _____

Obstetrical History

Total Pregnancies: _____

Full Term: _____

Preterm: _____

Miscarriages /Abortions: _____

Hospital Admissions/Surgery

First day of last menstrual period: _____

Age of first cycle: _____

Last pap smear: _____

Last bloodwork: _____

Cycle length: _____

Age of Menopause: _____

Last mammogram: _____

Please check if you or a blood relative had/have any of the following conditions.

	You	Family
Heart Disease		
Respiratory Disease		
High Blood Pressure		
Breast Disease		
Peptic Ulcer		
Bowel Disorder		
Kidney Disease		
Urinary Disease		
Urinary Incontinence		
Urinary Infections		
Diabetes		
Thyroid Disease		
Cancer		
Mental Retardation		
Arthritis		
Depression		
Pain with Intercourse		
Sexual Dysfunction		

Do you smoke? _____ How many packs/day?

Do you drink alcohol? _____

Do you use drugs? _____ Type of drugs _____

Have you ever been abused sexually, mentally, or emotionally?

Please feel free to make any additional comments below.