New Patient Medical History

Dale R. Myers MD

Sally Whitman PA-C

Name:_____ Date of Birth:_____ Date:_____

Reason for Todays Visit:_____

Pharmacy - Local:_____ Mail Order:_____

Primary Care Provider:_____

Drug Allergies	Reaction Type

Last Menstrual Period Date: _____

History of Abnormal: Pap _____no _____yes

Mammogram _____no _____yes

Last PAP Smear: _____

Done at:_____

Last Mammogram:_____

Done at:_____

Last Pregnancy (Date) :_____ Total #____

Colonoscopy (Year/Physician):_____

DEXA Scan (Year/Facility):_____

Current Medications: Attach List if Available – Continue on Back if need more space

Name	Dose	How Often?