

BROOMFIELD MEDICAL ASSOCIATES, PC

Name: _____ Age _____ Date: ___ / ___ / _____

Patient History

How did you hear about us? _____

What is the reason or condition that brings you to our office?

List all of your medical conditions:

List all prior surgeries:

List all medications and dosages (include over the counter, herbs, vitamins)

Have you been hospitalized in the past 6 months? Y N If so, for what condition?

Allergies to medications? Y N Please list: _____
Allergies to IV contrast dyes? Y N Shellfish or iodine? Y N
Do you or have you smoked tobacco products? Y N Packs per day _____ for _____ years
Do you drink alcohol? Y N Drinks per week _____

Significant Family Medical History (i.e.: cancers, heart disease, diabetes, stroke, etc.)

Significant Gynecological History _____

Occupation: _____

Do you have any suspicious skin moles you would like the doctor to look at? Y N

What do you enjoy doing? Do you have any special interests or hobbies?

We are considering a number of ancillary services to meet the needs of the community.
Would you be interested in having us provide any of the following services? (Circle all that apply)

- | | | |
|----------------------|----------------------------|-----------------------------------|
| Massage Therapy | Cosmetic Laser Dermatology | Cardiac Monitoring |
| Stress Testing | Lung Function Testing | Acupuncture |
| Bone Density Testing | Allergy Testing | Trigger Point Injections for Pain |