



Boulder Medical Center
Patient Information Verification Form

Patient Name _____ DOB _____ Age _____ Date _____

Primary Care Physician _____

Thank you for completing all questions

Current Height/Weight Height _____ Weight _____

Weight Change? Yes _____ Gain/Loss _____ How Much? _____

Please list all Allergies that you have

Table with 2 columns: Name, Effect. Multiple rows for listing allergies.

Please list all PRESCRIPTION medications that you take

Table with 3 columns: Name, Dose, Frequency. Multiple rows for listing prescription medications.

List all OVER THE COUNTER medications that you take

Table with 3 columns: Name, Dose, Frequency. Multiple rows for listing over-the-counter medications.

Medical History: (Check all that apply)

- List of medical conditions with checkboxes: AIDS/HIV, Alcoholism, Allergies, Anemia, Anorexia, Appendicitis, Arthritis, Asthma, Bleeding Disorders, Breast Lump, Bronchitis, Bulimia, Cancer, Cataracts, Chemical Dependency, Chicken Pox, COPD, Cancer, Diabetes, Emphysema, Epilepsy, Fractures, Glaucoma, GERD, Gout, Heart Disease, Hernia, Hepatitis (A, B or C), Herniated Disk, High Blood Pressure, Previous Heart Attack, High Blood Pressure, High Cholesterol, Kidney Disease, Liver Disease, Measles, Migraine Headaches, Multiple Sclerosis, Osteoporosis, Pacemaker, Parkinson's Disease, Pneumonia, Prostate Problem, Psychiatric Care, Rheumatoid Arthritis, STD's, Stroke, Suicide Attempt, Thyroid Disease, Tonsillitis, Tuberculosis, Ulcers.

Other _____

Please provide information about previous surgeries, hospitalizations and significant injuries (include date or year).

Table with 2 columns: Description, Date/Year. Multiple rows for listing medical history.

Please provide information about previous tests, immunization and examinations (include date or year of the last).

Physical Exam _____ Flu Shot _____ Pneumococcal Vaccine _____

Male

Colonoscopy _____

Female

Colonoscopy _____ Pap _____

Mammogram _____ Dexa Scan _____

Social History:

Tobacco Use: Never Current: _____ pack(s) per day, _____ year's total Former: _____ year quit

Patient Signature _____

Date _____
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