



SPRUCE STREET INTERNAL MEDICINE

2575 Spruce Street Boulder CO 80302-3806

303-449-3594

COMPLETE MEDICAL HISTORY FORM

DATE: _____

NAME: _____ AGE: _____ DATE OF BIRTH: _____

I. PAST MEDICAL HISTORY

A. Surgeries:

T & A (tonsils) Date: _____ Hysterectomy Date: _____

Appendectomy Date: _____ Ovaries removed? Yes No (circle)

Cholecystectomy Date: _____ Was hysterectomy done to treat a cancer? Yes No
(gallbladder)

Other surgeries and dates: _____

Biopsies done: what kind and dates: _____

B. Hospitalizations: (other than for surgeries)

Date: _____ Where: _____ Reason? _____

C. Injuries/Fractures (type, date and how injured):

D. Present Medications (prescription and over-the-counter):

Name	Dose	#Taken daily	Reason

Herbs and Supplements: _____

E. Allergies: _____ or No known drug allergies

Medications: _____ What reaction: _____

Other Substances, Foods, etc:

F. Immunizations: Check Childhood Shots Given:

DPT _____ Mumps _____ Measles _____ Rubella _____ Polio _____ Smallpox _____
Tetanus Booster Date: _____
Pneumovax (pneumonia vaccine) Date: _____
Influenza (date of last shot) Date: _____
Hepatitis B (series of 3 shots) Date: _____
Others: Date: _____

II. FAMILY HISTORY

Mother: Age (if living) _____ Age (at death) _____ Cause of death _____

List any medical problems she has had:

Father: Age (if living) _____ Age (at death) _____ Cause of death _____

List any medical problems he has had:

Brother (s) Ages and any medical problems he/they have had: _____

Sister (s) Ages and any medical problems she/they have had: _____

Any other blood relatives with:

	Relationship		Relationship
Diabetes	_____	High blood pressure	_____
Heart attack	_____	Breast cancer	_____
Stroke	_____	Colon cancer	_____
Tuberculosis	_____	High cholesterol	_____
Alzheimer's	_____	Melanoma (skin cancer)	_____
Prostate cancer	_____	Ovarian cancer	_____

III. LIFESTYLE HISTORY

A. Marital Status:

Single Married Divorced
Significant Other (male) Significant other (female)

B. Have you ever been pregnant? Yes No N/A

If yes, how many pregnancies? _____ How many births / children? _____

C. smoker (currently) ex-smoker nonsmoker chewing tobacco

If a smoker, number of packs (pipes, cigars) per day: _____

How long have you smoked? _____ If ex-smoker, when did you quit? _____

D. Alcohol intake:

What do you usually drink? _____ how much? _____ how often? _____

Do not drink alcohol

LIFESTYLE HISTORY, continued

E. Exercise:

Do you exercise regularly? _____ What activity? _____
 How often? _____ How long is each session? _____

F. Diet -Check any foods you **avoid** in your diet:

salt sugar fats (oils) red meat eggs poultry wheat caffeine
 other _____

G. Usual number of meals per day: _____ Number of times per week you eat "fast foods" _____

H. Travel ; Have you recently traveled outside the U.S.? _____

Where did you go? _____

I. Work

Current Occupation: _____

Have you had any work related illnesses or injuries? _____

Injury/Illness while employed as:

Do you have a history of exposure to toxic chemicals or substances? Yes No

What Where When

IV. REVIEW OF SYSTEMS

A. In the past, have you been diagnosed as having any of the following conditions? Check and date:

<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Varicose veins	
<input type="checkbox"/> Hardening of the arteries		<input type="checkbox"/> Phlebitis (blood clots)	
<input type="checkbox"/> Heart attack		<input type="checkbox"/> Migraine headaches	
<input type="checkbox"/> Stroke or "TIA"		<input type="checkbox"/> Cluster headaches	
<input type="checkbox"/> Heart Murmur		<input type="checkbox"/> Tension headaches	
<input type="checkbox"/> Angina		<input type="checkbox"/> Congestive heart failure	
<input type="checkbox"/> Cataracts		<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Sinusitis		<input type="checkbox"/> Menieres Disease	
<input type="checkbox"/> Nasal polyps		<input type="checkbox"/> Allergic rhinitis	
<input type="checkbox"/> Tonsillitis		<input type="checkbox"/> Gum disease	
<input type="checkbox"/> Cervical (neck) strain		<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Lupus		<input type="checkbox"/> Rheumatoid arthritis	
<input type="checkbox"/> Emphysema		<input type="checkbox"/> Chronic bronchitis	
<input type="checkbox"/> Pneumonia		<input type="checkbox"/> Asthma	
<input type="checkbox"/> Fibrocystic breast disease		<input type="checkbox"/> Galactorrhea(breast discharge)	
<input type="checkbox"/> Hyperthyroidism (over-active thyroid)		<input type="checkbox"/> Hypothyroidism (low thyroid)	
<input type="checkbox"/> Pernicious anemia		<input type="checkbox"/> Lymphoma	
<input type="checkbox"/> Peptic ulcer (gastric or duodenal)		<input type="checkbox"/> Iron deficiency anemia	
<input type="checkbox"/> Gastritis/Esophagitis		<input type="checkbox"/> Giardia or other parasite	
<input type="checkbox"/> Intestinal polyps		<input type="checkbox"/> Malabsorption	
<input type="checkbox"/> Diverticulosis		<input type="checkbox"/> Diverticulitis	

REVIEW OF SYSTEMS (continued)			
<input type="checkbox"/> Irritable bowel (spastic colon)		<input type="checkbox"/> Chronic Fatigue syndrome	
<input type="checkbox"/> Reflux or GERD		<input type="checkbox"/> Enlarged prostate	
<input type="checkbox"/> Fibromyalgia		<input type="checkbox"/> Crohn's colitis	
<input type="checkbox"/> Ulcerative colitis		<input type="checkbox"/> Prostatitis (prostate infection)	
<input type="checkbox"/> Hemorrhoids		<input type="checkbox"/> Pelvic inflammatory disease	
<input type="checkbox"/> Epididymitis		<input type="checkbox"/> Uterine Fibroids	
<input type="checkbox"/> Dysmenorrhea		<input type="checkbox"/> Cystitis(bladder infection)	
<input type="checkbox"/> Vaginitis		<input type="checkbox"/> Hepatitis A, B or C	
<input type="checkbox"/> Pyelonephritis (kidney infection)		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Kidney Stone		<input type="checkbox"/> Gallstones	
<input type="checkbox"/> Hypoglycemia		<input type="checkbox"/> PMS or PMDD	
<input type="checkbox"/> Bulimia or Anorexia		<input type="checkbox"/> Depression	
<input type="checkbox"/> Any kind of Cancer		<input type="checkbox"/> Multiple sclerosis	
What kind?		<input type="checkbox"/> Neurologic disease	
<input type="checkbox"/> Abnormal x-ray findings:		<input type="checkbox"/> Panic attacks	
Describe		<input type="checkbox"/> High cholesterol or Triglycerides	
<input type="checkbox"/> Abnormal pap smear		<input type="checkbox"/> Sexual dysfunction	

B. Presently or in the recent past, have you had any of the following symptoms:

<input type="checkbox"/> Recurrent headaches		<input type="checkbox"/> Weight loss	# of pounds lost	
<input type="checkbox"/> Fever (unexplained)		<input type="checkbox"/> Chills		
<input type="checkbox"/> Generalized fatigue		<input type="checkbox"/> Generalized weakness		
<input type="checkbox"/> Double vision		<input type="checkbox"/> Ringing in ears		
<input type="checkbox"/> Recurrent sinus infection		<input type="checkbox"/> Recurrent sore throats		
<input type="checkbox"/> Hoarseness		<input type="checkbox"/> Neck stiffness		
<input type="checkbox"/> Coughing up blood		<input type="checkbox"/> Chronic cough		
<input type="checkbox"/> Chest pressure or tightness on exertion		<input type="checkbox"/> Chest pressure of tightness at rest		
<input type="checkbox"/> Feeling dizzy or off-balance		<input type="checkbox"/> Pain in legs while walking		
<input type="checkbox"/> Change in appetite		<input type="checkbox"/> Abdominal burning pain		
<input type="checkbox"/> Nausea		<input type="checkbox"/> Diarrhea		
<input type="checkbox"/> Change in bowel habits		<input type="checkbox"/> Rectal bleeding		
<input type="checkbox"/> Painful urination		<input type="checkbox"/> Change in urinary habits		
<input type="checkbox"/> Breast Pain		<input type="checkbox"/> Weight gain	# of pounds gained	
<input type="checkbox"/> Night Sweats		<input type="checkbox"/> Generalized body aches		
<input type="checkbox"/> Change in vision		<input type="checkbox"/> Change in hearing		
<input type="checkbox"/> Frequent nosebleeds		<input type="checkbox"/> Recurrent gum or tooth infections		
<input type="checkbox"/> Constant sinus drainage		<input type="checkbox"/> Trouble swallowing		
<input type="checkbox"/> Swollen glands		<input type="checkbox"/> Shortness of breath on exertion		
<input type="checkbox"/> Shortness of breath while laying down		<input type="checkbox"/> Coughing up phlegm in the morning		
<input type="checkbox"/> Feeling faint or almost passing out		<input type="checkbox"/> Swollen ankles or feet		
<input type="checkbox"/> Heartburn or indigestion		<input type="checkbox"/> Abdominal cramping pain		
<input type="checkbox"/> Vomiting		<input type="checkbox"/> Constipation		
<input type="checkbox"/> Blood in or on stool		<input type="checkbox"/> Frequent or urgent urination		
<input type="checkbox"/> Blood in urine		<input type="checkbox"/> Vaginal discharge or odor		
<input type="checkbox"/> Change in menstrual periods		<input type="checkbox"/> Change in sexual desire		
<input type="checkbox"/> Breast lump		<input type="checkbox"/> Nipple discharge		
<input type="checkbox"/> Testicular pain		<input type="checkbox"/> Skin rash		
<input type="checkbox"/> Easy bruising or bleeding		<input type="checkbox"/> Changes in hair		

B. Presently or in the recent past, have you had any of the following symptoms:			
<input type="checkbox"/> Trouble sleeping		<input type="checkbox"/> Depression	
<input type="checkbox"/> Muscle weakness or pain		<input type="checkbox"/> Tingling in hands or feet	
<input type="checkbox"/> Joint swelling		<input type="checkbox"/> Testicular swelling	
<input type="checkbox"/> Changes in skin or moles		<input type="checkbox"/> Lumps in neck, underarms or groin	
<input type="checkbox"/> Sensation of being too hot or too cold		<input type="checkbox"/> Nervousness, panic	
<input type="checkbox"/> Mood swings		<input type="checkbox"/> Numbness	
<input type="checkbox"/> Joint pains		<input type="checkbox"/> Seizures or convulsions	
<input type="checkbox"/> Head injury and loss of consciousness		<input type="checkbox"/> Memory loss	

List any other problems not mentioned above:

V. HEALTH MAINTENANCE

- A. Date of last physical / annual exam _____
Examiner _____
- B. Date of last Pap smear _____
- C. Date of last Cholesterol level _____
- D. Date of last EKG _____
- E. Date of last Chest X-ray _____
- F. Date of last Prostate exam _____
- G. Date of last Complete blood tests _____
- H. Date of last Thyroid level _____
- I. Date of last Sigmoidoscopy or Colonoscopy _____
- J. Date of last Bone density test _____
- K. Date of last mammogram _____
- L. Do you use a seat belt in your car? _____

VI. CHIEF COMPLAINT: Please list below the main reason for your visit today and other specific concerns or problems you want the doctor to discuss with you. **Reason for visit:**



SPRUCE STREET INTERNAL MEDICINE

2575 Spruce Street Boulder CO 80302-3806

303-449-3594

Acknowledgement of Privacy Consent Form

I hereby give consent to Spruce Street Internal Medicine, LLC, to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by request.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf and delivered to 2575 Spruce Street, Boulder, CO. 80302. You may deliver your revocation by any means you choose, personally or by mail, but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Sign: _____ Date: _____

Print name of patient: _____

If you are signing as the patient's representative:

Print your name: _____

Describe your authority: _____

Spruce Street Internal Medicine, LLC

Patient Information

Date: _____ Social Security Number: _____

PATIENT NAME: _____ Date of Birth ____/____/____ Sex F M

Home Address: _____ City _____ State ____ Zip _____

Home phone: _____ Marital Status _____

Email: _____ Occupation: _____

Employed by: _____ Employer phone: _____

SPOUSE or PARENT

Name: _____ Home Phone: _____

Address: _____ City _____ State ____ Zip _____

Employed by: _____ Work Phone: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____

Relationship: _____ Phone: _____

Referred to our office by: _____

Insurance Information

Name of the POLICY HOLDER or SUBSCRIBER: _____

Name of the INSURANCE COMPANY: _____

ID or POLICY NUMBER: _____ Group Number: _____

Name of POLICY HOLDER or SUBSCRIBER'S EMPLOYER: _____

Agreement for Payment of Services :

We believe that prompt payment for our services is part of the contract that exists between doctor and patient. We will provide you and your family with quality medical services, including after hours coverage, 24 hours a day, 7 days a week, and you agree to pay us promptly for our services.

I understand that I am responsible for all charges for services provided for me or my family, regardless of insurance coverage, and that payment is due at the time services are rendered unless my physician has a contract with my insurance company to bill the insurance company first.

I agree to pay any co-payments or deductible amounts for which I am responsible under my insurance policy at the time of service; if I must be billed for co-payments, then I agree to pay a \$5.00 billing fee in addition to my co-payment. I agree to pay for any services that I have received which are subsequently determined to be "not covered" by my insurance; if my insurance has a deductible or a co-insurance, I understand that I may be asked for a credit card at the time of service to which such fees may be charged. All bills for services are due upon receipt, and any balance that remains unpaid for 30 days or longer will be charged a \$35 late fee.

If my account is referred to a collection agency or attorney, I understand that I will be liable for the collection fees, attorney's fees and any court costs, in addition to my outstanding balance. For services provided to me, or my family, while a patient in the hospital, I request that payment under my insurance be made directly to the doctor who provided the service. I authorize the release of medical information necessary to process my claim, if such information is requested by my insurance company.

Signed: _____ Date: _____



2575 Spruce Street
Boulder CO 80302
Telephone: (303) 449-3594
Fax: (303) 447-0462
www.sprucestreetinternalmedicine.com

Guarantee of Payment Consent Form

Patient Name: _____
Last First Middle Initial

I understand that my insurance will be billed for each visit and then I will be billed by Spruce Street Internal Medicine for any deductible or coinsurance due. I have two weeks to remit.

I AUTHORIZE SPRUCE STREET INTERNAL MEDICINE to charge my payment card for the balance due if I have not *PAID OR CONTACTED* Spruce Street Internal Medicine for payment arrangements.

Card Holder Name Card Holder Signature

Card Number Expiration Date

Card Type:

MasterCard

Visa



MEDICATION DISPENSING PROGRAM

This is to inform you that we have implemented an in-office Medication Dispensing Program, primarily for sick patients, to save a trip to the pharmacy.

This is an added value service option. The service is being provided as an added convenience to our patients, at prices comparable to those offered at your local pharmacy or you insurance co-pay.

We do not accept insurance for this service, or file forms for insurance.

You may submit your receipt for flexible spending accounts if you wish to do so.

If you would like to participate in this service OPTION please acknowledge your desire to participate with your signature below:

I, _____ am interested in participating in the Medication Dispensing Program. I understand the Medication Dispensing Program is an OPTION offered to me. I am neither obligated nor required to participate.

Patient Signature

Date

PLEASE FAX THIS FORM TO YOUR FORMER PHYSICIAN/PROVIDER



Spruce Street Internal Medicine, LLC
2595 Spruce Street, Boulder, Colorado 80302

303-449-3594

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use of disclosure of the named individual's health information as described below:

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Telephone number: _____

Address: _____

Please send my records to:

Spruce Street Internal Medicine, LLC
2575 Spruce Street, Boulder CO. 80302

Purpose of request: _____

Treatment dates: _____

The following information is to be disclosed:

_____ Physician notes _____ Lab Results _____ Complete Record
_____ MRI scans _____ X-rays
_____ other _____

SENSITIVE INFORMATION: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

REDISCLOSURE: I understand that any disclosure of information carries with it the potential for redisclosure and that the information may not be protected by federal confidentiality rules.

RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

OTHER RIGHTS: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition (If you do not specify a date, event, or condition, this authorization will expire in six months).

SIGNATURE OF PATIENT: _____

DATE: _____

If signed by legal representative, relationship to patient: _____

