Today's Date: _____ Referred by Dr. _____
Patient name: _____
Reason for Scan _____
Date of Birth _____ Age: ___
Race: _____ Male / Female (circle)
Address :_____
_____

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

Phone number: _____
SSIM number: _____
Technician _____

Have you

- Had a previous bone density scan? Yes __ No __
  If Yes, When & Where? _____ Result _____
- Had anorexia or bulimia? Yes __ No __ Age ____
- Had kidney disease? Yes __ No __ Age ____
- Had thyroid disease or taken thyroid medication? Yes __ No __ Age ____
- Had spinal surgery or a hip replacement? Yes __ No __ Age ____
- Broken any bones after age 25? Yes __ No __, if so which bone, when and how?

_____

- Is there a family history of osteoporosis? Yes __ No __ If yes, who? _____
- Do you exercise? Yes __ No __ How often and what type _____
- Are you presently a smoker? Yes __ No __ Past Smoker? Yes __ No __
  ____ # of years _____ Packs per day Quit when? _____
- Do you take calcium? Yes __ No __ mgs per day ____ length of time taken? ____
- Do you take a multi-vitamin daily? Yes __ No __ Do you take vitamin D? Yes __ No __
- How many servings of dairy do you have daily? _____
- Are you lactose intolerant? Yes __ No __
- How many alcoholic beverages do you consume weekly? _____
- Taken or are currently taking steroids (e.g. prednisone - cortisone) Yes __ No __
  If yes, how long and dosage _____
- **Circle** any of the following medications taken and indicate when (here) _____
  Actonel Fosamax Forteo Miacalcin Evista Boniva
- List all current medications you are presently taking. _____
  _____
  _____

Female Only:

- Have you gone through menopause? Yes __ No __ Age ____
- Had a hysterectomy? Yes __ No __ Age ____ Ovaries removed? Yes __ No __ Age ___
- Taken hormone replacement therapy? Yes __ No __ How long? ____
- Had breast or uterine cancer? Yes __ No __ Age ____
- Is there any chance that you could be pregnant? Yes __ No __

Men Only:

- Have you had prostate cancer? Yes __ No __ Age ____
- Have you been diagnosed as having testicular dysfunction? Yes __ No __

SPRUCE STREET INTERNAL MEDICINE, A PROFESSIONAL LLC

PATIENT INFORMATION

DATE:_____ SOCIAL SECURITY NUMBER:_____

PATIENT NAME:_____ DATE OF BIRTH:_____/_____/_____ SEX M F

HOME ADDRESS:_____ CITY:_____ STATE:_____ ZIP_____

HOME PHONE:_____ MARITAL STATUS:_____

EMPLOYED BY:_____ OCCUPATION:_____

EMPLOYER PHONE:_____

SPOUSE OR PARENT NAME:_____ HOME PHONE:_____

INSURANCE INFORMATION

NAME OF THE POLICY HOLDER OR SUBSCRIBER:_____

POLICY HOLDER OR SUBSCRIBER'S DATE OF BIRTH:_____(Necessary for HIPAA compliance)

NAME OF THE INSURANCE COMPANY:_____

ID OR POLICY NUMBER:_____ GROUP NUMBER:_____

NAME OF POLICY HOLDER OR SUBSCRIBER'S EMPLOYER:_____

THE ABOVE INSURANCE COVERS: DIAGNOSTIC PREVENTATIVE BOTH TYPES OF COVERAGE

(PLEASE CIRCLE ONE) **INITIALS:**_____