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?_____ lf 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:

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

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

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

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

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

Vl. 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:**

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

SPRUCE STREET INTERNAL MEDICINE is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

ENTITY TO RECEIVE INFORMATION. Check each person/entity that you approve to receive information.	**DESCRIPTION OF INFORMATION TO BE RELEASED.** Check each that can be given to person/entity on the left in the same section.
VOICE MAIL	Account Information Appointment Information Medical Information (Rx's, treatment, etc.)
SPOUSE'S NAME:	Account Information Appointment Information Medical Information (Rx's, treatment, etc.)
PARENT'S NAME:	Account Information Appointment Information Medical Information (Rx's, treatment, etc.)
OTHER NAME AND RELATIONSHIP:	Account Information Appointment Information Medical Information (Rx's, treatment, etc.)

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document.

If there is any topic of information not listed above that you do not wish disclosed with the person(s) listed as authorized contacts, please list these items here:

_____

_____

_____

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization shall be in effect until revoked by the patient.

_____Date:_____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)

SPRUCE STREET INTERNAL MEDICINE

PATIENT INFORMATION

Date:_____**DATE OF BIRTH**: _____

PATIENT NAME:_____

SEX: M F Marital Status: Single Married SS # _____

Home Address:_____City:_____

State:_____Zip_____Cell Phone _____ Hm Phone:_____

May we leave a detailed message on your: Cell Home Work

Email:_____ for sending confidential test results, etc

Permanent or Alternate Address: Is this the best address to use?? Yes____No____

Address:_____

City:_____State:_____Zip _____

Employed By:_____Work Phone:_____

Occupation:_____

IN CASE OF EMERGENCY, PLEASE NOTIFY:_____

Relationship:_____Phone:_____

Referred to our office by:_____

Language Preference, if other than English:_____

Do you need a translator? Y N

INSURANCE INFORMATION

Name of the POLICY HOLDER or SUBSCRIBER:_____

Subscriber's Employer: _____

Name of the INSURANCE COMPANY:_____

ID or POLICY NUMBER: _____Group Number _____

POLICY HOLDER or SUBSCRIBER'S Date of Birth _____

(HIPAA required)

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 30 days to pay.

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

28 April 2012

Spruce Street Internal Medicine, LLC
2595 Spruce Street, Boulder, Colorado 80302
303-449-3594

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 understanding 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. In 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: _____

REFERRAL REQUEST

Spruce Street Internal Medicine, LLC
2575 Spruce Street, Boulder Co 80302
Phone: 303-449-3594 Fax:303-449-3112

Request Date: _____ Appointment Date (if already made):_____

Patient Name: _____

Phone: _____ Patient Date of Birth: _____

Insurance Company: _____

Insurance ID# _____ Insurance Group# _____

Your PCP: H Browne S Ling K Johnson

Auth: H Browne S Ling K Johnson

Referred to: _____
Name Address

_____
City Phone

Procedure: Consult Testing Evaluate & Treat

_____ With / Without Contrast (if applicable)

CPT
Codes: _____ _____ _____ _____ _____ _____

Reasons:

_____ ICD-9 Code: _____

_____ ICD-9 Code: _____

_____ ICD-9 Code: _____

Approved: YES NO

Auth # _____ # of visits _____ Start Date:_____ Exp:_____

If you need this referral to be faxed to your specialist,
please provide their fax number here:

_____

Please allow 72 hours for your referral to be processed. You will be notified when your referral is approved or denied.

Insurance is through what employement or association?_____

Name of Primary Policy Holder for your Insurance Plan? _____

Primary Policy Holder's Date of Birth _____**(Necessary for HIPAA Compliance)**

The above insurance covers (please circle one):

DIAGNOSTIC SCREENING/PREVENTATIVE BOTH TYPES OF COVERAGE Initials ___

I authorize and request payment of medical benefits from the above insurance company to my physician for services provided on this date.

I certify that this is a copy of my current medical insurance card and that, to the best of my knowledge, this insurance is in effect as of this date.

I understand that if this insurance information is later found to be incorrect, I will be responsible for prompt payment of today's charges and that I will be refunded any balance due to me once my correct insurance settles the claim for this visit.
Initials _____

_____

Date of Visit Patient Name Patient Signature Date of Birth

_____

Current Address City State Zip Code

_____

Home Phone Work Phone Cell Phone

May we Leave messages for your about any test results at: Home?___ Work?_____ Cell?_____

Email Address: _____

Is there someone you authorize us to speak with about your care at Spruce Street Internal Medicine?

Yes No

_____

Name Relationship Best Phone Number

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DATE OF BIRTH: _____

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Description of Personal Representative's Authority (attach necessary documentation)