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: _____

Have you SSIM number: _____ Technician _____

- ❑ 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? _____
- ❑ Parent with hip fracture? Yes ___ No ___
- ❑ 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, LLC

Patient Information

Date: _____ Social Security Number: _____

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

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: _____

Name of the INSURANCE COMPANY: _____

ID or POLICY NUMBER: _____ Group Number: _____

Name of POLICY HOLDER or SUBSCRIBER'S EMPLOYER: _____

The above insurance covers (please circle one)

DIAGNOSTIC PREVENTATIVE BOTH TYPES OF COVERAGE

Initials _____

W _____ PH _____ H_____