Osteoporosis and Abnormal Bone Density History Form

Date of first appointment: ____/____/____ (month / day / year) Email: _____

Name: _____ (last / first / middle initial / maiden) Birthdate: ____/____/____ (month / day / year)

Address: _____ (street / apt#) Age _____ Sex: ☐ F ☐ M

_____ (city / state / zip) Telephone: Home: ( ) _____ Work: ( ) _____

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

EDUCATION *(circle highest level attendec):*

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/Average per work: _____

Referred here by: *(check one)* ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? ☐ Yes ☐ No If yes, Name: _____

GENERAL INFORMATION (Please Circle Yes or No):

Have you had a bone density test? Yes No If yes: When _____ Where _____

Do you exercise? Yes No If yes, what do you do? _____

How long do you exercise? _____ How many days per week? _____

Have you had a fall? Yes No How many times have you fallen in the past 12 months? _____

BROKEN BONES:

What broken bones/ fractures have you had? How old were you at the time and how did they happen?

_____

_____

_____

_____

YOUR HISTORY (Please Circle Yes or No):

If you feel you have lost height, how much? _____

Do you have any history of bone cancer? Yes No Have you ever had radiation treatment? Yes No

Have you ever been treated for cancer with chemotherapy? Yes No

Do you get regular dental care? Yes No Do you have full or partial dentures? Yes No

For women only (Please Circle Yes or No):

At what age was your last period? _____

Have you ever had cancer of the breast, ovary, uterus or cervix? _____

Are you taking medicine for breast cancer? Yes No What is the name: _____

Have you had a hysterectomy? Yes No If so, were the ovaries removed? Yes No

Did you ever take estrogen or hormones? Yes No If yes, how long? _____

For men only (Please Circle Yes or No):

Do you have low testosterone? Yes No

Have you had cancer of the prostate? Yes No Are you taking medicine for prostate cancer? Yes No

If yes, what? _____

Other Osteoporosis Questions (Please Circle Yes or No)

Do you weigh less than 127 lbs? Yes No

Do you have rheumatoid arthritis? Yes No

Do you have kidney failure? Yes No

Do you have a history of frequent infections/ or a weakened immune system? Yes No

Have you had vitamin D deficiency? Yes No

Do you have lactose intolerance? Yes No

Do you have acid reflux/ GERD? Yes No

Have you ever had hyperthyroidism or hypothyroidism? (an overactive or underactive thyroid gland) Yes No

Have you had hyperparathyroidism? Yes No

Do you have problems with high calcium in your blood? Yes No

Do you have inflammatory bowel disease, such as Crohn's? Yes No

Have you been on steroids (prednisone or cortisone) for 3 or more months in your lifetime? Yes No

Do you have intestinal malabsorption, such as celiac disease? Yes No

Have you ever had an eating disorder? Yes No

Do you have any oral surgery or tooth extractions planned or scheduled? Yes No

Have you had a heart attack or stroke in the past year? Yes No

MEDICATIONS

Drug allergies: ☐ No ☐ Yes If yes, please list: _____

Type of reaction: _____

PRESENT MEDICATIONS *(List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)*

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not At All
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

Please provide details requested below if you have ever taken any of the listed medications

Medication	Strength (mg etc)	Date Started	Date Stopped	Reason Stopped
Calcium				
Calcium with Vitamin D				
Vitamin D				
Multivitamin				
Estrogen (pill, patch, shot)				
Testosterone				
Fosamax (Alendronate)				
Actonel				
Boniva				
Miacalcin nasal spray (calcitonin)				
Forteo				
Tymlos				
Reclast (zoledronic acid)				
Evista				
Prolia				
Evenity				
Depo-Provera				
Tamoxifen				
Sensipar				
Arimidex (anastrozole)				

SYSTEMS REVIEW

As you review the following list, please check any problems, which have significantly affected you:

Date of last mammogram:____/____/____ Date of last eye exam:____/____/____ Date of last chest x-ray:____/____/____

Date of last Tuberculosis Test____/____/____

Constitutional
- ☐ Recent weight gain amount _____
- ☐ Recent weight loss amount _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Eyes
- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye
- ☐ Itching eyes

Ears-Nose-Mouth-Throat
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose
- ☐ Runny nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty swallowing

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory
- ☐ Shortness of breath
- ☐ Difficulty breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing (asthma)

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting of blood or coffee ground material
- ☐ Stomach pain relieved by food or milk
- ☐ Jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn

Genitourinary
- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

For Women Only:

Age when periods began: _____

Periods regular? ☐ Yes ☐ No

How many days apart? _____

Date of last period? ____/____/____

Date of last pap? ____/____/____

Bleeding after menopause? ☐ Yes ☐ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal
- ☐ Morning stiffness

  Lasting how long?

  _____ Minutes _____ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling

  List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold

Neurological System
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss
- ☐ Night sweats

Psychiatric
- ☐ Excessive worries
- ☐ Anxiety
- ☐ Easily losing temper
- ☐ Depression
- ☐ Agitation
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Endocrine
- ☐ Excessive thirst

Hematologic/Lymphatic
- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion/when _____

Allergic/Immunologic
- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

Patient's Name: _____ Date: _____ Physician Initials: _____

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day?_____

Do you smoke? ☐ Yes ☐ No ☐ Past – How long ago?_____

Do you drink alcohol? ☐ Yes ☐ No Number per week _____

Has anyone ever told you to cut down on your drinking?

☐ Yes ☐ No

Do you use drugs for reasons that are not medical? ☐ Yes ☐ No

If yes, please list: _____

_____

Do you exercise regularly? ☐ Yes ☐ No

Type_____

Amount per week _____

How many hours of sleep do you get at night?_____

Do you get enough sleep at night? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Do you now have or have you ever had: *(check if "yes)*

☐ Cancer	☐ Heart problems	☐ Asthma
☐ Goiter	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epilepsy
☐ Nervous breakdown	☐ Stomach ulcers	☐ Rheumatic fever
☐ Bad headaches	☐ Jaundice	☐ Colitis
☐ Kidney disease	☐ Pneumonia	☐ Psoriasis
☐ Anemia	☐ HIV/AIDS	☐ High Blood Pressure
☐ Emphysema	☐ Glaucoma	☐ Tuberculosis

Other significant illness *(please list)* _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

PREVIOUS SURGERIES

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ☐ No ☐ Yes *Describe:*_____

Any other serious injuries? ☐ No ☐ Yes *Describe:*_____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings_____ Number living_____ Number deceased_____

Number of children_____ Number living_____ Number deceased_____ List ages of each _____

Health of children_____

_____

Do you know any blood relative who has or had: (check and give relationship)

☐ Cancer _____	☐ Heart disease _____	☐ Rheumatic fever_____	☐ Tuberculosis_____
☐ Leukemia_____	☐ High blood pressure_____	☐ Epilepsy_____	☐ Diabetes_____
☐ Stroke _____	☐ Bleeding tendency_____	☐ Asthma_____	☐ Goiter_____
☐ Colitis_____	☐ Alcoholism _____	☐ Psoriasis_____	

Patient's Name:_____ Date:_____ Physician Initials: _____