Bone Health Consultation: Patient History Form

GENERAL INFORMATION:

Patient Name ____ Today's Date ___________________

DOB__________Sex_________Ethnic Group: African-American ___Caucasian____Hispanic____Other _____

Have you had a bone density test? Yes No If yes: When_____________Where __________________

Have you been diagnosed in the past with osteopenia or osteoporosis? Yes No

DIET AND HABITS:

How many servings of dairy products do you consume per day? _______________________________________
(1 serving is a glass of milk, an ounce of cheese, a cup of cottage cheese or a container of yogurt)

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

How long do you exercise? ______________________ How many days per week? _____________________

Do you smoke? Yes No If yes, how many packs per day? ________ If you stopped smoking, how old were you when you stopped? ________ How many years did you smoke? _________________________________

Do you drink alcohol? Yes No If yes, how many drinks per day__________per week _______________

BROKEN BONES:

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

____

____

Operations (Type of surgery and date): ____

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STRENGTH AND BALANCE:

Have you lost strength? Yes No

Do you have problems getting out of a chair? Yes No

Do you have problems with your balance? Yes No If yes, what kind? ____________________

Do you use a walking aid? Yes No If yes, what kind? ____________________

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

When was your last fall and what happened? ____________________

____

FAMILY HISTORY:

Do any of your blood relatives have osteoporosis? Yes No Who? ____________________

Did either one of your parents ever break a hip after the age of 50? Yes No

YOUR HISTORY:

How tall were you at age 20?__________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:

At what age was your first period? __________ 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:

Do you have erectile dysfunction (impotence)? Yes 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:

Do you weigh less than 127 lbs? Yes No

Do you have rheumatoid arthritis? Yes No

Do you have kidney disease/failure? Yes No

Do you have Diabetes? Yes No

Do you have COPD? Yes No

Do you have chronic liver disease? Yes No

Do you have a history of TB (tuberculosis)? 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
(an overactive 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

Are you allergic to any medicines? (List below)____ Yes No

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Local Pharmacy: Name:_______________________________ Phone # ______________________________

Mail Order Pharmacy (If applicable): Name:______________________Phone # ___________________________

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

Medication	Strength	Date Started	Date Stopped	Reason Stopped
Anticonvulsants				
Calcium				
Cancer medications				
Casodex				
Cyclosporine				
Depo-Provera (Medroxyprogesterone)				
Depression/Anxiety medications				
Diabetes medications				
Estrogen (pill, patch, inj)				
GERD/Reflux medications				
Insulin				
Lithium				
Lupron				
Multivitamin				
Prednisone				
Tamoxifen				
Testosterone				
Thyroid medications				
Vitamin D				
Actonel, Atelvia (Risedronate)				
Aredia (Pamidronate)				
Boniva (Ibandronate)				
Duavee (Bazodoxifene)				
Evenity (Romosozumab)				
Evista (Raloxifene)				
Forteo (Teriparatide)				
Fosamax, Binosto (Alendronate)				
Miacalcin, Fortical (Calcitonin)				
Prolia (Denosumab)				
Reclast, Zometa (Zoledronic acid)				
Tymlos (Abaloparatide)				

Please list any other medicines and dose you are currently on: ______________________________

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