

Osteoporosis Patient History Form

Please answer the following questions to help us in the treatment of your bones. If you are not sure how to answer a question, leave the space blank and we will assist you with your answer. All answers will of course be kept in strict confidence and treated as medical record information.

Name: _____

Age: _____ Weight: _____

Height: _____ Height at Age 25: _____ Difference in Height: _____

Race: African American Asian Caucasian Hispanic
 Native American Other: _____

Sex: Female Male

Referring Physician (if any): _____

Important Questions About Your Health:

- Have you fractured any bones during your adult life? Yes No
- Does your family have a history of osteoporosis? Yes No
- Do you smoke more than half a pack of cigarettes per day? Yes No
- Have you smoked in the past? Yes No
- How many servings of dairy products do you have every day?
(one serving = 8 oz milk, 1.5 oz. Cheese, 8 oz. Yogurt, 8 oz.
cottage cheese, or 4 oz of ice cream) Number: _____
- Have you consumed three or more dairy servings per day
throughout most of your life? Yes No
- Do you take calcium supplements daily? Yes No
If so, how much?
 0-500 mg/day 501-1000 mg/day >1000 mg/day
- Do you spend at least 20 minutes outside each day? Yes No
- Do you take any Vitamin D supplements daily? Yes No
If so, how much
 0-200 IU 201-400 IU 400-800 IU >800 IU
- Do you do physical activity at least three times per week Yes No
If yes, what type of exercise: _____
- Do you drink more than two alcoholic beverages per day? Yes No
- Do you drink more than 2 cups of coffee or 4 cans (8 ounces)
of caffeinated soda per day? Yes No

Have you ever taken any of the following medications or treatments

- Steroids (prednisone, cortisone, etc.) Yes No
- Thyroid medication Yes No
- Anticonvulsants (for seizures, epilepsy) Yes No
- Loop diuretics (Lasix, Bumex, Edicrin) Yes No
- Heparin Yes No
- Chemotherapy Yes No
- Lithium Yes No
- Methotrexate (medication for rheumatoid arthritis) Yes No
- Antacids containing aluminum Yes No
- Cholestyramine (Questran to lower cholesterol) Yes No
- Sleeping aids Yes No

Have you had any of the following conditions?

- Hyperthyroidism or hyperparathyroidism Yes No
- Biliary cirrhosis Yes No
- Kidney disease Yes No
- Rheumatoid arthritis Yes No
- Other arthritis Yes No
- Part of your stomach removed Yes No
- Intestinal or bowel disease Yes No
- Eating disorders (anorexia nervosa, bulimia etc.) Yes No

Have you had any recent falls or loss of balance? Yes No

Do you have any general comments or questions about your health? _____

-----Remaining Questions for Women Only-----

- Have you gone through menopause Yes No
- Did your menopause occur before age 45? Yes No
- If yes to any of the above, what age did you go through menopause? _____
- Have you ever had amenorrhea
(missed periods or never started periods)? Yes No
- Have you ever taken hormones (not including birth control pills)? Yes No
- If so, for how many years? _____
- Have you ever been treated for osteoporosis or weak bones? Yes No
- If so, what was the treatment? _____
- Have you had any of the following conditions?
- Hysterectomy (womb removed) Yes No
 - Ovaries removed Yes No
 - If yes to any of the above, what age did you have the surgery? _____