

Patient Name: _____

Date: _____

Referred by: _____

DOB: _____

Patient Medical History for Bone Health Patients

Please bring this completed form *along with a list of your current medications and supplements (or bring all your medication bottles)* to your appointment.

Have you broken any bones after the age of 40? NO YES

Bone	Date	How did it happen (e.g. car accident, fall, etc.)?

Have you taken any of these medications (now or in the past)?

Medication	When to When?	Why you stopped?
Alendronate / Fozamax <input type="checkbox"/> NO <input type="checkbox"/> YES		
Risedronate / Actonel <input type="checkbox"/> NO <input type="checkbox"/> YES		
Ibandronate / Boniva <input type="checkbox"/> NO <input type="checkbox"/> YES		
Zoledronate / Reclast <input type="checkbox"/> NO <input type="checkbox"/> YES		
Denosumab / Prolia <input type="checkbox"/> NO <input type="checkbox"/> YES		
Teriparatide / Forteo <input type="checkbox"/> NO <input type="checkbox"/> YES		
Raloxifene / Evista <input type="checkbox"/> NO <input type="checkbox"/> YES		

Past Medical History

Condition	Condition
Parathyroid Disease <input type="checkbox"/> NO <input type="checkbox"/> YES	Celiac Disease <input type="checkbox"/> NO <input type="checkbox"/> YES
Thyroid Disease <input type="checkbox"/> NO <input type="checkbox"/> YES	Seizure <input type="checkbox"/> NO <input type="checkbox"/> YES
Organ Transplant <input type="checkbox"/> NO <input type="checkbox"/> YES	Cancer (Type _____) <input type="checkbox"/> NO <input type="checkbox"/> YES
Type and Date:	Year of Diagnosis: _____ <input type="checkbox"/> Surgery <input type="checkbox"/> Radiation <input type="checkbox"/> Chemotherapy If breast cancer: <input type="checkbox"/> Tamoxifen _____ to _____ <input type="checkbox"/> Aromatase Inhibitor _____ to _____

Does Osteoporosis run in your family? Mother Father Other(s) _____

Did either of your parents break a Hip? Mother Father

For Women:

I still have periods. They are Regular Irregular

I have gone through menopause. Age or Date of last menstrual period: _____

I have used hormone replacement / estrogen therapy. Date: _____ to _____

Symptom Review

What was your tallest height? _____	What is your current height? _____
Have you gained or lost 10 lbs. in the past year? <input type="checkbox"/> NO <input type="checkbox"/> YES	Do you have chronic diarrhea? <input type="checkbox"/> NO <input type="checkbox"/> YES
Have you ever had a kidney stone? <input type="checkbox"/> NO <input type="checkbox"/> YES	Do you have wheezing or shortness of breath? <input type="checkbox"/> NO <input type="checkbox"/> YES
Do you have problems with balance? <input type="checkbox"/> NO <input type="checkbox"/> YES	Do you have problems with vision? <input type="checkbox"/> NO <input type="checkbox"/> YES
Have you had an irregular heart rhythm? <input type="checkbox"/> NO <input type="checkbox"/> YES	Do you have any dental procedures needed / planned? <input type="checkbox"/> NO <input type="checkbox"/> YES
Do you have heartburn / reflux symptoms? <input type="checkbox"/> NO <input type="checkbox"/> YES	<i>For men:</i> Do you have ED or low sex drive? <input type="checkbox"/> NO <input type="checkbox"/> YES

Do you exercise regularly? <input type="checkbox"/> NO <input type="checkbox"/> YES	_____ minutes per day _____ days per week.
Do (or Did) you smoke? <input type="checkbox"/> NO <input type="checkbox"/> YES	_____ packs per days for _____ years. Quit Date: _____
Do you drink alcohol? <input type="checkbox"/> NO <input type="checkbox"/> YES	_____ drinks per day / week.
Have you fallen in the past year? <input type="checkbox"/> NO <input type="checkbox"/> YES	If yes, how many times? _____
Have you ever taken prednisone or another steroid medications? <input type="checkbox"/> NO <input type="checkbox"/> YES	Date(s) / Duration:

Calcium Intake Calculator: *Please fill in the table with the intake you have most every day.*

Dietary Calcium Sources	Mg of calcium per serving	Servings per day	For Clinic Use ONLY
General Diet	200-300	1	
Milk – 1 cup	300		
Yogurt – 6 oz.	300		
Cheese** - 1.5 oz.	300		
TOTAL Brand Cereal – ¾ Cup	1000		
OJ (Calcium Added) 1 cup	300		

****For Example: Cheddar, Mozzarella. DO NOT COUNT Cottage Cheese or Cream Cheese.****

Supplemental Calcium Sources	Mg of calcium per tablet	IU of Vitamin D per tablet	Number of Tablets per Day	For Clinic Use ONLY
Multivitamin				
Calcium Carbonate				
Calcium Citrate				
Vitamin D (plain)	N/A			