Osteoporosis Consultation: Patient History Form
Greenville Health System: Department of Orthopaedics

GENERAL INFORMATION:

Patient Name _______________________________________________    Today’s Date___________________
DOB__________  Sex _____  Ethnic Group: African-American ___ Caucasian___ Hispanic___ Other ________
Occupation or former occupation _____________________________   Are you retired? __________________
Who referred you here? ______________________________________________________________________
Who is your primary care physician/ provider? ____________________________________________________
What is the reason for this consultation? ______________________________________________________________________
Have you had a bone density test?   Yes      No          If yes:   When _______________  Where _________________

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?
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

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This document has been provided by: Greenville Hospital System University Medical Center
Date: 08/2018

If you have any questions about this Material, please contact Own the Bone at (847) 318-7336.
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 parent ever fall and break a hip? Yes No Who? _______________________________

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
Operations (Type of surgery and date): _________________________________________________________
__________________________________________________________________________________________

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 failure?  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

__________________________________________________________________________________________

Local Pharmacy: Name:_____________________________  Phone # ________________________________

Mail Order Pharmacy (If applicable): Name:_____________________  Phone # __________________________

Thank you very much for filling out these forms. This will help us provide better care to you and improve the visit.
Please provide details requested below if you have ever taken any of the listed medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Strength (mg etc)</th>
<th>Date Started</th>
<th>Date Stopped</th>
<th>Reason Stopped</th>
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<tbody>
<tr>
<td>Calcium</td>
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<tr>
<td>Calcium with Vitamin D</td>
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<tr>
<td>Vitamin D</td>
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<tr>
<td>Multivitamin</td>
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<td>Estrogen (pill, patch, shot)</td>
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<tr>
<td>Testosterone</td>
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<tr>
<td>Fosamax (Alendronate)</td>
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<td>Actonel</td>
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<td>Evista</td>
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<td>Miacalcin nasal spray (calcitonin)</td>
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<td>Forteo</td>
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<td>Boniva</td>
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<td>Reclast (zoledronic acid)</td>
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<td>Zometa</td>
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<td>Aredia</td>
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<td>Depo-Provera</td>
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<td>Dilantin (phenytoin)</td>
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<td>Phenobarbital</td>
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<td>Tegretol (carbamazeoine)</td>
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<td>Depakote (valporic acid)</td>
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<td>Tamoxifen</td>
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<td>Arimidex (anastrozole)</td>
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<td>Femara (letrozole)</td>
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<td>Lupron</td>
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<td>Casodex</td>
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Please list any other medicines and dose you are currently on:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
MEDICAL HISTORY FORM

PLEASE CHECK TO INDICATE ANY RECENT SYMPTOMS

GENERAL
☐ AIDS
☐ AIDS RISK FACTORS
☐ DEPRESSED
☐ FEVER
☐ LOSS OF APPETITE
☐ NERVOUS
☐ TIRED
☐ TROUBLE SLEEPING
☐ WEIGHT GAIN
☐ WEIGHT LOSS

EYES
☐ RED EYE
☐ VISUAL PROBLEMS

ENT
☐ DIZZINESS
☐ HAY FEVER
☐ HEADACHES
☐ HEARING PROBLEMS
☐ DENTAL PROBLEMS

ENDOCRINE
☐ DIABETES
☐ THYROID DISEASE

RESPIRATORY
☐ ASTHMA
☐ COUGHING
☐ COUGHING BLOOD
☐ SHORT OF BREATH

CARDIOVASCULAR
☐ CHEST DISCOMFORT
☐ CHEST PAIN
☐ HEART ATTACK
☐ HEART MURMUR
☐ HEART SKIPPING
☐ HIGH BLOOD PRESSURE
☐ HIGH CHOLESTEROL

GASTROINTESTINAL
☐ ABDOMINAL PAIN
☐ BLACK STOOL
☐ BLOOD IN STOOL
☐ CHANGE IN STOOLS
☐ CONSTIPATION
☐ DIARRHEA
☐ GALL STONES
☐ HEARTBURN
☐ HEMORRHOIDS
☐ HEPATITIS
☐ INDIGESTION
☐ JAUNDICE
☐ NAUSEA
☐ TROUBLE SWALLOWING
☐ ULCER
☐ VOMITING
☐ VOMITING BLOOD

UROLOGICAL
☐ BLADDER INFECTIONS
☐ BLOOD IN URINE
☐ BURNING ON URINATION
☐ FREQUENT URINATION
☐ KIDNEY INFECTIONS
☐ KIDNEY STONE

HEMATOLOGICAL
☐ ANEMIA
☐ BLEEDING PROBLEM
☐ BLOOD CLOTS

MUSCULO-SKELETAL
☐ ARTHRITIS
☐ BACK PAIN
☐ GOUT
☐ SWOLLEN JOINTS

OSTEOPOROSIS
☐ LOW BONE DENSITY
☐ OSTEOPOROSIS
☐ BROKEN BONE

MALE ONLY
☐ IMPOTENCE
☐ PAINFUL TESTICLE
☐ PENILE DISCHARGE
☐ PROSTATE PROBLEMS
☐ SWOLLEN TESTICLE
☐ WEAK STREAM

FEMALE ONLY
☐ BREAST LUMP
☐ HOT FLASHES
☐ SWEATS
☐ PELVIC PAIN
☐ VAGINAL DISCHARGE

ANY OTHER PROBLEMS?

_________________________________________

_________________________________________

Reviewed by: