

Shady Grove Orthopaedics Osteoporosis Clinic

Medical Information

Name: _____ Date: _____
 Street Address: _____ City: _____ State: ____ Zip Code: _____
 Home Phone: _____ Date of Birth: _____ Sex: __ Female __ Male
 Ht.: ____ Wt.: ____ Race: __ African American __ Caucasian __ Asian __ Hispanic __ Other
 Primary Care Physician: _____ Gynecologist: _____

When was your last bone density scan? _____

Do you fall frequently? ____ Yes ____ No

The bones you have broken as an adult include: _____

How were they fixed? ____ Casting ____ Pins ____ Surgery Do you still have implants in? ____ Yes ____ No

Does anyone in your family have osteoporosis or have ever broken a hip or wrist:

Have you used oral prednisone or medrol dose pack for more than 3 months? ____ Yes ____ No

Do you have macular degeneration or cataracts? ____ Yes ____ No

Please circle all Medical Conditions you have been diagnosed with:

- | | | |
|----------------------------------|---------------------------------|---------------------------------|
| <i>High blood pressure</i> | <i>Osteoporosis</i> | <i>Any other not mentioned:</i> |
| <i>Stroke</i> | <i>GERD/Reflux</i> | _____ |
| <i>Coronary artery disease</i> | <i>Swallowing problems</i> | _____ |
| <i>Diabetes Type 1 or Type 2</i> | <i>Kidney problems</i> | _____ |
| <i>History of heart attack</i> | <i>Lung problems</i> | _____ |
| <i>Thyroid problems</i> | <i>Parathyroid problems</i> | _____ |
| <i>Vitamin D Deficiency</i> | <i>Blood clots</i> | _____ |
| <i>Lactose intolerance</i> | <i>Irritable bowel syndrome</i> | _____ |

Do you have any allergies to medications? _____

Please list medications you take: _____

Medication	Dose	How Often	Condition Taken For

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Please list the surgeries you have had:

Surgery	Date	Reason

Do you smoke? ___ Yes ___ No When did you quit? _____

Do you drink alcohol? ___ Yes ___ No

Do you drink caffeine? ___ Yes ___ No Frequency and quantity? _____

Do you exercise? ___ Yes ___ No Frequency and activity? _____

Do you take a calcium supplement or multivitamin? ___ Yes ___ No

For women: When was your first period? _____

 When did you go through menopause? _____

 Have you ever been on hormone replacement therapy (HRT): ___ Yes ___ No

 If yes, for how long, and when did you stop? _____

Have you had any of the following conditions?

 Hysterectomy ___ Yes ___ No

 Breast Cancer ___ Yes ___ No

 Uterine Cancer ___ Yes ___ No

 Mastocytosis ___ Yes ___ No

 Taken Tamoxifen ___ Yes ___ No

For men: Have you ever had testosterone insufficiency? ___ Yes ___ No

 Have you ever had prostate cancer? ___ Yes ___ No