

Name _____

Date of Birth _____

Osteoporosis Evaluation New Patient Form

Medical History

Fracture since age 50	Chronic lung disease
Rheumatoid arthritis	Cancer _____
Back pain	Inflammatory bowel disease
Hyperthyroid (over-active)	Liver problems
Hypothyroid (under-active)	Cushing's disease
Poor vision	Multiple sclerosis
Loss of height How Much? _____	Other: _____

How do you rate your current health?

Excellent	Very Good	Fair	Poor
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Social Habits

Do you currently smoke or use any tobacco product? Yes No

If yes, how many cigarettes a day? _____

Did you previously smoke or use any tobacco product? Yes No

If yes, how many cigarettes a day? _____

How many years did you smoke for? _____

When did you quit? _____

Alcohol Consumption (# of drinks a week/month) ___/week or ___/month

Do you ever have more than 2 drinks a day? Yes No

Females Only: Are you post-menopausal? Yes No If yes, age of menopause _____

Do you fall easily? Yes No

Any falls in the last 2 months? Yes No

How do you rate your current activity level?

Sedentary (walk only if needed for activities in home such as going to the kitchen)
Mild Activity (able to walk malls)
Moderate (exercises 1-3 times a week in addition to daily activities)
Active (exercises 4+ times a week or a total of 4+ hours a week)

How do you rate your lifetime calcium intake?

Poor	Moderate	Good
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Family History

Has anyone in your family been diagnosed with osteopenia (low bone mass) or osteoporosis? Yes No If yes, who? _____

Did either of your parents lose height as they got older?

Yes No If yes, who? _____

Has any relative had a known osteoporotic fracture?

Yes No If yes, what type? _____ (hip, vertebral, etc.)

Surgeries

Type:	Date:
Type:	Date:
Type:	Date:
Type:	Date:
Type:	Date:
Type:	Date:

Medication History

Please check all that apply: I take or have taken at one time the following medications -

<input type="checkbox"/>	Steroids (for more than 30 days; prednisone, medrol)
<input type="checkbox"/>	Cancer chemotherapy
<input type="checkbox"/>	Radiation therapy for cancer
<input type="checkbox"/>	Thyroid medications
<input type="checkbox"/>	Anti-Epileptic medications (depakote, lamictal, topamax, tegretol, etc.)
<input type="checkbox"/>	Gonadal hormone suppression (Lupron, etc.)
<input type="checkbox"/>	Immunosuppressive medications

Current Medications

Medication:	Reason:
Medication:	Reason:
Medication:	Reason:
Medication:	Reason:
Medication:	Reason:
Medication:	Reason:
Medication:	Reason:
Medication:	Reason:

Supplements

Calcium (amount and type if known): _____

Vitamin D (units per day if known): _____

Referral Information

Doctor referring you to our practice: _____

Primary care physician or other physicians you would like a copy of this consult sent to:
(if not in Austin please give fax or phone #) _____
