Patient Osteoporosis History

Paris Orthopedics and Sports Medicine

Office Use ONLY
Blood Pressure: ______________
Temperature: ______________
Heart Rate: ______________

Date: ______________

Patient Name: ____

DOB: **Age:** **Sex:** **Current Height:** **Maximum Height:** **Weight:**

Have you been diagnosed with osteoporosis or osteopenia? Yes or No

Who is your PCP? ______________

Have you had a fracture after the age of 50? ______________________

How did it occur? ______________

When was your last DEXA? ______________________________

Where was it performed? ______________________________

Has a grandparent, parent, or sibling had osteoporosis or a fall that resulted in a fracture? Yes or No

Do you have a history of any of the following?
IF NONE CHECK HERE: ☐

Diabetes	Y	N	*COPD/Asthma*	Y	N
Seizures	Y	N	*GERD/Reflux*	Y	N
Kidney disease	Y	N	*Thyroid Issue*……………	Y	N
Cancer	Y	N	*Radiation treatments*	Y	N
Rheumatoid Arthritis	Y	N	*Lupus*	Y	N
Blood clots	Y	N	*Difficulty swallowing*	Y	N

Have you ever taken any of the following medications?

Fosamax/Alendronate	Reclast	Tymlos	*Seizure meds*
Boniva/Ibandronate	Prolia	Evista	Chemotherapy
Actonel/Risedronate	Forteo	*Topamax*	*Prednisone/steroids*

Men: Have you had testosterone levels check? Yes or No

Women: When did you go through menopause? _________

Were you ever placed on hormones? Yes or No

Have you ever had any of the following surgeries?

Hysterectomy complete or partial Year:______
Oopherectomy (ovaries) Year:______
Lap band, gastric sleeve, gastric bypass Year:______
Joint replacement Year:________
Spinal surgery Year:________

Do you take calcium, vitamin D or K, or multivitamins?

1. ______________________ **Dosage:** __________
2. ______________________ **Dosage:** __________
3. ______________________ **Dosage:** __________
4. ______________________ **Dosage:** __________

What are your current medications?

1 ______________________ **5** ______________________
2 ______________________ **6** ______________________
3 ______________________ **7** ______________________
4 ______________________ **8** ______________________

Medication allergies? ____

Do you exercise regularly? ____

Have you had more than 2 falls in the last year? ______________________________

Do you use an assistive device for mobility? cane walker wheelchair scooter

Do you Smoke? *Currently Never Former* **Packs per day?** _________ **Year Started?** ______ **Year Stopped?** _______

Do you use Smokeless Tobacco? *Currently Never Former* **Year Started?** ______ **Year Stopped?** _______

Do you drink Alcohol? *YES or NO* **How Frequently?** ___________

What is your current living situation? Living at home Living with family Assisted living facility Nursing Home

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