



Please complete the following questions to the best of your ability. If you are unclear what to answer, leave the space blank and we will help with the answer when you are seen at this facility. All answers will be kept in strict confidence and treated as information in your medical record.

1. Your Name: \_\_\_\_\_

2. Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

3. Date of Birth: \_\_\_\_\_

4. Referring Physician: \_\_\_\_\_

5. Race:  Caucasian  Afro-American  Oriental  Native American  
 Other: \_\_\_\_\_

6. Sex:  Female  Male

7. Have you fractured any bones during your adult life? .....  Yes .....  No

8. Is there a family history of osteoporosis? .....  Yes .....  No

9. Do you smoke more than 1/2 pack per day? .....  Yes .....  No

10. Have you smoked in the past? .....  Yes .....  No

11. How many servings of dairy products do you consume per day?  
(one serving = 8oz of milk, 1 oz. of cheese, container of yogurt or a serving of ice cream) ..... \_\_\_\_\_

12. Have you consumed three or more daily servings per day?  
(as defined above) for of your life? .....  Yes .....  No

13. Do you take a calcium supplement daily? .....  Yes .....  No  
If so, how much?    0 - 500 mg/day  
                              501 - 1000 mg/day  
                              >1000 mg/day

14. Do you exercise at least three times a week? .....  Yes .....  No

15. Do you drink more than two alcoholic drinks a day? .....  Yes .....  No

16. Have you taken any of the following medications?  
a. Steroids (premisone, cortisone, etc.) .....  Yes .....  No  
b. Thyroid medication? .....  Yes .....  No  
c. Anticonvulsants (for seizures, epilepsy)? .....  Yes .....  No



17. Have you had any of the following conditions?

- a) Partial or complete paralysis? .....  Yes .....  No
- b) Hyperthyroidism (over-active thyroid)? .....  Yes .....  No
- c) Kidney disease? .....  Yes .....  No
- d) Rheumatoid arthritis? .....  Yes .....  No
- e) Other arthritis? .....  Yes .....  No
- f) Parts of stomach removed? .....  Yes .....  No
- g) Intestinal or bowel disease? .....  Yes .....  No

For women only:

- h) Hysterectomy (womb removed)? .....  Yes .....  No
- i) Ovaries removed? .....  Yes .....  No
- j) Blood clots? .....  Yes .....  No
- k) If yes, were you on hormones at the time? .....  Yes .....  No
- l) Breast cancer? .....  Yes .....  No
- m) Family history of breast cancer? .....  Yes .....  No
- n) Cancer of the uterus (womb)? .....  Yes .....  No

18. How tall are you? \_\_\_\_\_

19. How did you hear about us? \_\_\_\_\_

20. Do you have any general comments or questions about your past health? \_\_\_\_\_

**REMAINING QUESTIONS FOR FEMALES ONLY**

21. Have you gone through menopause (change of life)? .....  Yes .....  No

22. Did your menopause occur before age 45? .....  Yes .....  No

23. Do you have amenorrhea (never started period or ended at a young age)? .....  Yes .....  No

24. Do you now take hormones (premarin, estrogens, etc)? .....  Yes .....  No

25. Have you taken hormones (not including birth control pills) in the past? .....  Yes .....  No

26. Have you had side affects from hormones? .....  Yes .....  No

- a) Breast soreness? .....  Yes .....  No
- b) Heavy periods or other bleeding? .....  Yes .....  No
- c) Headaches? .....  Yes .....  No
- d) Weight gain or fluid build-up? .....  Yes .....  No
- e) Other? .....  Yes .....  No

27. How long have you taken or did you take hormones: \_\_\_\_\_ years

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**For Office Use Only**

Height: \_\_\_\_\_ inches      Weight: \_\_\_\_\_ pounds      MRN: \_\_\_\_\_

