LewisGale Physicians
HCA Virginia Health System
An HCA affiliate

Patient Name: _____ DOB: _____

Patient Medical History for Osteoporosis Patients

Referred by: _____ Date of Injury/Onset of Symptoms: _____

Please bring this completed form *along with a list of your current medications and supplements (or bring all your medication bottles)* **to your appointment.**

Have you broken any bones after the age of 40? ☐NO ☐YES

Bone	Date	How did it happen (e.g. car accident, fall, etc.)?

Have you taken any of these medications (currently or in the past)?

Medication		Date Range?	Reason for discontinuing?
Alendronate / Fosamax	☐NO ☐YES		
Risedronate / Actonel	☐NO ☐YES		
Ibandronate / Boniva	☐NO ☐YES		
Zoledronate / Reclast	☐NO ☐YES		
Denosumab / Prolia	☐NO ☐YES		
Teriparatide / Forteo	☐NO ☐YES		
Raloxifene / Evista	☐NO ☐YES		
Romosozumab / Evenity	☐NO ☐YES		

Past Medical History

Condition	Condition
Parathyroid Disease ☐NO ☐YES	Celiac Disease ☐NO ☐YES
Thyroid Disease ☐NO ☐YES	Seizure ☐NO ☐YES
Organ Transplant ☐NO ☐YES	Cancer (Type_____) ☐NO ☐YES
Type and Date:	Year of Diagnosis: _____ ☐Surgery ☐Radiation ☐Chemotherapy If breast cancer: ☐Tamoxifen _____ to _____ ☐Aromatase Inhibitor _____ to _____

Does Osteoporosis run in your family? ☐Mother ☐Father ☐Other(s) _____

Did either of your parents break a hip? ☐Mother ☐Father

For Women:

☐I still have periods. They are ☐ Regular ☐ Irregular

☐ I have gone through menopause. Age or Date of last menstrual period: _____

☐ I have used hormone replacement / estrogen therapy. Date: _____ to _____

Symptom Review

What was your tallest height? _____	What is your current height? _____
Have your gained or lost 10 lbs. in the past year? ☐NO ☐YES	Do you have chronic diarrhea? ☐NO ☐YES
Have you ever had a kidney stone? ☐NO ☐YES	Do you have wheezing or shortness of breath? ☐NO ☐YES
Do you have problems with balance? ☐NO ☐YES	Do you have problems with vision? ☐NO ☐YES
Have you had an irregular heart rhythm? ☐NO ☐YES	Do you have any dental procedures needed / planned? ☐NO ☐YES
Do you have heartburn / reflux symptoms? ☐NO ☐YES	*For men:* Do you have ED or low sex drive? ☐NO ☐YES

Do you exercise regularly? ☐NO ☐YES	_____ minutes per day _____ days per week.
Do (or Did) you smoke? ☐NO ☐YES	____ packs per days for _____ years. Quit Date: _____
Do you drink alcohol? ☐NO ☐YES	_____ drinks per day / week.
Have you fallen in the past year? ☐NO ☐YES	If yes, how many times? _____
Have you ever taken prednisone or another steroid medications? ☐NO ☐YES	Date(s) / Duration:

Calcium Intake Calculator: *Please fill in the table with the intake you have <u>most every day</u>.*

Dietary Calcium Sources	**Mg of calcium per serving**	**Servings per day**	**For Clinic Use ONLY**
General Diet	200-300	1	
Milk – 1 cup	300		
Yogurt – 6 oz.	300		
Cheese** - 1.5 oz.	300		
TOTAL Brand Cereal – ¾ Cup	1000		
OJ (Calcium Added) 1 cup	300		

****For Example: Cheddar, Mozzarella. DO NOT COUNT Cottage Cheese or Cream Cheese.****

Supplemental Calcium Sources	**Mg of calcium per tablet**	**IU of Vitamin D per tablet**	**Number of Tablets per Day**	**For Clinic Use ONLY**
Multivitamin				
Calcium Carbonate				
Calcium Citrate				
Vitamin D (plain)	N/A			