

**OSTEOPOROSIS HISTORY**  
**New Mexico Clinical Research and Osteoporosis Center**  
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**GENERAL INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: M F (circle) Marital Status: \_\_\_\_\_

Ethnic background: \_\_\_\_\_

Are you retired? Y N

Occupation or Prior Occupation \_\_\_\_\_

Who referred you here? \_\_\_\_\_

Who is your primary care doctor? \_\_\_\_\_

Is there anyone else you would like to get a copy of this consultation? \_\_\_\_\_

How can we help you? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DIET AND HABITS**

Describe your diet: \_\_\_\_\_

\_\_\_\_\_

How many servings of dairy products do you consume per day? \_\_\_\_\_

(1 serving is a glass of milk, an ounce of cheese, a cup of cottage cheese, or a container of yogurt)

Do you salt your food? Y N

Do you have lactose or dairy intolerance? Y N

Do you exercise? Y N What do you do? \_\_\_\_\_

\_\_\_\_\_

How long do you do it? \_\_\_\_\_ How many days per week? \_\_\_\_\_

Do you smoke? Y N How many packs per day? \_\_\_\_\_

If you stopped smoking, how old were you when you stopped? \_\_\_\_\_

How many years did you smoke? \_\_\_\_\_

Do you consume alcohol? Y N

How much per week? \_\_\_\_\_

## **BROKEN BONES**

What bone fractures have you had, how did they happen and how old were you at the time?

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## **STRENGTH AND BALANCE**

Have you lost strength? Y N

Do you have problems getting out of a chair? Y N

Do you have balance problems? Y N What kind? \_\_\_\_\_

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Do you use an walking aid or mobility aid? Y N What kind? \_\_\_\_\_

Have you had a fall? Y N

When was your last fall and what happened? \_\_\_\_\_

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## **FAMILY HISTORY**

Do any of your blood relatives have osteoporosis? Y N Who? \_\_\_\_\_

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Do any of your blood relatives have osteopenia (low bone density)? Y N Who? \_\_\_\_\_

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Has any one in the family had a bone fracture? Y N

(We are particularly interested in hip fractures)

Who, at what age and what type of fracture?

Who \_\_\_\_\_ Age \_\_\_\_\_ Type \_\_\_\_\_

Who \_\_\_\_\_ Age \_\_\_\_\_ Type \_\_\_\_\_

Who \_\_\_\_\_ Age \_\_\_\_\_ Type \_\_\_\_\_

**YOUR HISTORY**

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Are you allergic to any medications? Y N

What medications are you allergic to and what reactions do you have from them?

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How tall were you at age 20? \_\_\_\_\_

If you feel you have lost height, how much? \_\_\_\_\_

Please circle any of these illnesses that you have had and explain below if necessary:

- |                                       |  |
|---------------------------------------|--|
| Osteoporosis                          | Gastrointestinal disorder              |
| Osteopenia                            | Esophageal Stricture                   |
| Heart disease                         | Ulcers                                 |
| Lung disease                          | Trouble swallowing                     |
| Kidney disease                        | Other GI disorder                      |
| Liver disease                         | Celiac Disease                         |
| Transplantation                       | Endometriosis                          |
| Cancer                                | Asthma                                 |
| Diabetes                              | Obesity Surgery (list age and date)    |
| Rheumatoid Arthritis                  | Other surgery (list age and date)      |
| Thyroid Disease                       | Asthma                                 |
| Kidney Stones                         | Hypertension                           |
| Paget's disease                       | Any other significant medical illness? |
| Stroke or other neurological disorder |  |

Explain Here: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For Females: Age at Menopause \_\_\_\_\_

Did you take estrogen? Y N

At what age did you start taking estrogen? \_\_\_\_\_

When did you stop or are you still on it? \_\_\_\_\_

For Males: Do you have testosterone deficiency? Y N

Do you have erectile dysfunction? Y N

Do you get regular dental care? Y N

**MEDICATION HISTORY**

Have you taken medications for osteoporosis or osteopenia? Y N

If so, what medications, when did you start them, when did you stop them, did you have problems with them and if so, what problems? List below:

Medication_____	Start_____	Stop_____	Problem Y N	What Problem? _____
Medication_____	Start_____	Stop_____	Problem Y N	What Problem? _____
Medication_____	Start_____	Stop_____	Problem Y N	What Problem? _____
Medication_____	Start_____	Stop_____	Problem Y N	What Problem? _____
Medication_____	Start_____	Stop_____	Problem Y N	What Problem? _____
Medication_____	Start_____	Stop_____	Problem Y N	What Problem? _____

Additional space to explain problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you taking prednisone or other steroids? Y N

Are you taking drugs to control the immune system? Y N

Are you taking drugs for prostate cancer? Y N

Are you taking antidepressants? Y N

Are you taking medicine for acid reflux or other stomach conditions? Y N

Do you take calcium? Y N What brand? \_\_\_\_\_

How many milligrams? \_\_\_\_\_

Do you split the dose? Y N

Do you take the calcium with food? Y N

Does your calcium have vitamin D in it? If so, how much? \_\_\_\_\_

Do you take extra vitamin D? Y N How much? \_\_\_\_\_

Do you take a multivitamin? Y N

Do you take strontium? Y N

Please list all your prescription medications (name and dose):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all over the counter supplements other than calcium, vitamin D and multivitamins:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you for filling out this history form. The doctor will fill in any missing details at your visit.