

Crystal Lake Orthopaedic Surgery & Sports Medicine, Ltd.

OSTEOPOROSIS CLINIC NEW PATIENT FORM

Today's Date: _____
 Patient Name: _____
 Gender: M F Age: _____ Height: _____ Weight: _____

Who is your Family Doctor? _____
 Who referred you for this appointment? _____
 Have you been diagnosed with osteoporosis in the past? YES NO
 If yes, what has been your treatment for osteoporosis? _____
 Have you had a previous bone density scan? YES NO year _____ Location _____

Please circle a response to the following questions:

Are you Caucasian or Asian?	YES	NO
Do you have fair skin?	YES	NO
Have you lost height as you aged?	YES	NO
Have you recently had a fall?	YES	NO
Have you ever taken any of the following medications:		
Steroids by mouth (example: Prednisone)	YES	NO
Thyroid medications	YES	NO
Seizure medications	YES	NO
Lithium	YES	NO
Tamoxifen	YES	NO
Heparin	YES	NO
Chemotherapy	YES	NO

Have you been diagnosed with any of the following:

Acid Reflux	YES	NO
Stomach Ulcers	YES	NO
Bleeding Disorder	YES	NO
Thyroid Problems	YES	NO
Liver or Kidney Disease	YES	NO
Chronic Lung Disease	YES	NO
Rheumatoid Arthritis	YES	NO
Epilepsy	YES	NO
Diabetes requiring Insulin	YES	NO
Chronic Intestinal Disorder (example: Crohns or malabsorption)	YES	NO
Eating Disorder	YES	NO
Part of stomach removed (example: Gastric Bypass Surgery)	YES	NO
Paget's Disease	YES	NO
Cancer	YES	NO
Prolonged immobilization or hospitalization	YES	NO
Dementia		
Fracture as an Adult	YES	NO
What bone? _____	Age at fracture _____	

List Medical Conditions:

List past surgeries and the year the surgery was performed:

If you are female, please answer:

Are you post-menopausal? YES NO Age at menopause _____
Have you ever had children? YES NO
Have you breast fed at least one child? YES NO

Medications (type and dosage, include over the counter and supplements):

Allergies to medications or latex: _____

Social History:

Occupation _____ Marital Status: _____ Do you have any children? _____
Do you drink caffeinated beverages? YES NO How much? _____ How often? _____
Do you smoke? YES NO If yes, how much? _____ packs per day for _____ years
Do you drink alcohol? YES NO How much? _____ How often? _____
Do you have a history of using street drugs? _____
Do you avoid milk or dairy products? YES NO If yes, why? _____
How often do you exercise? _____

Family History:

Do you have a close relative (like a parent or sibling) who has suffered
a broken hip, shoulder, wrist or spine after the age of 45? YES NO

If yes, please explain: _____

Has anyone in your family had:

Osteoporosis or Bone Disease	YES	NO
Gastrointestinal Disease	YES	NO
Thyroid Disorders	YES	NO
Liver or Kidney Disease	YES	NO
Diabetes	YES	NO

Review of Systems: (Circle all symptoms you currently experience)

Weight Change	Shortness of Breath	Blood in urine	Joint Swelling
Fatigue	Wheezing	Difficulty urinating	Anemia
Fever, Chills, Sweats	Cough	Irregular menses	Bleeding Tendency
Weakness	Chest Pain	Spotting	Trouble Walking
Headache	Heart Murmur	Goiter	Poor Balance
Recent Vision Change	Leg Swelling	Heat/Cold Intolerance	Speech Difficulty
Ear Pain	High Blood Pressure	Tremor	Numbness
Ringing in Ears	Calf pain walking	Allergies	Memory Difficulty
Hearing Loss	Constipation	Asthma	Anxiety
Runny Nose	Heart Burn	Hay fever	Depression
Nasal Congestion	Change in Appetite	Hives	Change in Sleep Pattern
Sore Throat	Blood in Stool	Joint Pain/Stiffness	Dizziness
Dental Problems	Diarrhea	Rashes	Pregnant

Patient Signature for Information Verification: _____