



**Osteoporosis
Treatment
Center**

Robert Howe, M.D., P.C.
281 Maple Street, East Longmeadow, MA., 01028
Ph: (413) 525 – 5160 Fax: (413) 525 - 5170

Osteoporosis Patient History Form

Please print your answers to the following questions to help us in the treatment of your bones. If you are not sure how to answer a question, leave the space blank and we will assist you with your answer. All answers will of course be kept in strict confidence and treated as medical record information.

Name: _____ Age: _____ Gender: ___ Male ___ Female
 Race: ___ Afrlcan American ___ Asian ___ Caucasian ___ Hispanic ___ Native American / Other: _____
 Height at Age 25? _____ Current Height: _____ Weight at Age 25? _____ Current Weight: _____
 What has been your thinnest adult weight? _____ How old were you? _____
 Referring Physician (if any): Name: _____ City, State: _____

Important Questions About Your Health

Have you ever had surgery of the spine, hips, legs, or arms? ___ Yes ___ No
If yes, describe what type of surgery you had and which side was affected:

Have you had a barium X-ray in the last 2 weeks? ___ Yes ___ No
 A nuclear medicine scan or injection of X-ray dye this past week? ___ Yes ___ No
 Have you ever had a bone density test? ___ Yes ___ No
If yes, when and where:

Have you ever broken a bone as an adult? ___ Yes ___ No
 Does your family have a history of osteoporosis? ___ Yes ___ No
 Has a parent or sibling had a broken bone from a simple fall or bump? ___ Yes ___ No
If yes, who and which bone?

How many times have you fallen in the past year? _____ times

Do you smoke cigarettes? ___ Yes ___ No
 Have you smoked in the past? ___ Yes ___ No
 Do you typically consume three or more dairy servings per day? ___ Yes ___ No
 Do you take calcium supplements daily? ___ Yes ___ No
 Do you spend at least 20 minutes outside each day? ___ Yes ___ No
 Do you take any Vitamin D supplements daily? ___ Yes ___ No
If yes, how much?

Do you do physical activity at least three times per week? ___ Yes ___ No
If yes, what type of exercise?

Do you drink more than two alcoholic beverages per day? ___ Yes ___ No
 Do you drink more than 2 cups of coffee or 4 cans of caffeinated soda per day? ___ Yes ___ No

Tell us about any medications you have taken, past and current conditions & treatments

Medications

Steroids (prednisone, cortisone. etc.) ___ Yes ___ No
 Thyroid medication ___ Yes ___ No
 Anticonvulsants (for seizures, epilepsy) ___ Yes ___ No
 Medication for prostate cancer ___ Yes ___ No
 Medication to prevent organ transplant rejection ___ Yes ___ No
 Loop diuretics (Lasix, Bumex, Edicrin) ___ Yes ___ No
 Heparin ___ Yes ___ No
 Chemotherapy ___ Yes ___ No
 Lithium ___ Yes ___ No
 Methotrexate ___ Yes ___ No
 Antacids containing aluminum ___ Yes ___ No
 Cholestyramine ___ Yes ___ No
 Sleeping aids ___ Yes ___ No
 Tamoxifen ___ Yes ___ No
 Arimidex or Femara ___ Yes ___ No
 Raloxifene (Evista) ___ Yes ___ No
 Testosterone ___ Yes ___ No
 Etidronat (Didronel) ___ Yes ___ No
 Alendronate (Fosamax) ___ Yes ___ No
 Risedronate (Actonel) ___ Yes ___ No
 Intravenous pamidronate (Aredia) ___ Yes ___ No
 Calcitonin (Miacalcin nasal spray) ___ Yes ___ No
 PTH (Forteo) ___ Yes ___ No
 Zoledronic acid (Zometa)(Reclast) ___ Yes ___ No

Conditions

Hyperthyroidism or high calcium? ___ Yes ___ No
 Breast cancer ___ Yes ___ No
 Any cancer ___ Yes ___ No
 Celiac sprue ___ Yes ___ No
 Biliary cirrhosis ___ Yes ___ No
 Kidney disease ___ Yes ___ No
 Rheumatoid arthritis ___ Yes ___ No
 Other arthritis ___ Yes ___ No
 Part of your stomach removed ___ Yes ___ No
 Intestinal or bowel disease ___ Yes ___ No
 Eating disorder ___ Yes ___ No
 Any recent falls or loss of balance ___ Yes ___ No

Questions for Women Only

Are you pregnant? ___ Yes ___ No

Still having menstrual periods? ___ Yes ___ No

Gone through menopause? ___ Yes ___ No
 If yes to menopause, what age did you go through it? _____

Before menopause, ever missed periods for 6 months or more, besides during pregnancy? ___ Yes ___ No

Have you ever taken hormones? (not including birth control pills) ___ Yes ___ No
 If so, for how many years? _____

Have you ever been treated for osteoporosis or weak bones? ___ Yes ___ No
 If so, what was the treatment? _____

Had a hysterectomy? ___ Yes ___ No