

Alexandria Women's Center

3304 Masonic Dr. Suite 4001, Alexandria, LA 71301  
318-443-7222

Name \_\_\_\_\_ Date \_\_\_\_\_

Referred by \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age \_\_\_\_\_ Ethnicity \_\_\_\_\_

Mature adult height \_\_\_\_\_ Present Height \_\_\_\_\_ Weight \_\_\_\_\_

Have you been diagnosed as having osteoporosis? Yes No  
If yes, by x-ray: \_\_\_\_\_ By previous BMD \_\_\_\_\_ Other \_\_\_\_\_

Menstrual History: Age of onset: \_\_\_\_\_ As an adult, were your periods regular? \_\_\_\_\_  
If no, explain: \_\_\_\_\_

Have you: Had a hysterectomy? Yes No Age: \_\_\_\_\_  
Had your ovaries removed? Yes No Age: \_\_\_\_\_  
Gone through menopause? Yes No Age: \_\_\_\_\_

Check any of the following that apply to you:

- |   |  |
|---|--|
| <input type="checkbox"/> Family history of osteoporosis               | <input type="checkbox"/> Parathyroid disease                     |
| <input type="checkbox"/> Rheumatoid Arthritis                         | <input type="checkbox"/> Back pain                               |
| <input type="checkbox"/> Diabetes                                     | <input type="checkbox"/> Surgery on back or either hip           |
| <input type="checkbox"/> Paget's disease                              | <input type="checkbox"/> Degenerative Kidney or<br>Liver disease |
| <input type="checkbox"/> Cushing's syndrome                           | <input type="checkbox"/> Breast cancer                           |
| <input type="checkbox"/> Uterine cancer                               | <input type="checkbox"/> Thyroid disease/dysfunction             |
| <input type="checkbox"/> Abdominal surgery: when _____ type _____     | <input type="checkbox"/> Bowel disease (type) _____              |
| <input type="checkbox"/> Cancer (type and date)                       |  |
| <input type="checkbox"/> Broken bone as an adult (list site and date) |  |
| <input type="checkbox"/> Organ Transplant                             |  |

Circle those that apply

- |   |  |
|---|--|
| Antacids _____ duration _____                         | Alcohol: amount weekly _____                   |
| Anticoagulants _____ duration _____                   | Caffeine: coffee _____ cups/day _____          |
| Steroids (Prednisone) _____ duration _____            | tea _____ glasses/day _____                    |
| Ditantin / Phenobarbital _____ duration _____         | soda _____ glasses/day _____                   |
| Evsta/Raloxifere _____ duration _____                 | Cigarettes: _____ packs per day _____          |
| Calcitonin (Miacalcin, Calcimar) _____ duration _____ | # of years _____ D/C _____                     |
| Didronel (Etidronate) _____ duration _____            | Lactose intolerance _____                      |
| Diuretics _____ duration _____                        | Daily calcium: dietary _____ supplement _____  |
| Fluoride _____ duration _____                         | Vitamin D: supplement _____ multivitamin _____ |
| Fosamax (Alendronate) _____ duration _____            | Exercise: type _____ days a wk _____           |
| Hormones:   |  |
| Estrogen/Progesterone _____ duration _____            |  |
| Synthroid _____ duration _____                        |  |

Additional Medications - (write on back of sheet)

FALL HISTORY: \_\_\_\_\_