OKLAHOMA BONE HEALTH

Review of Pertinent History for Females

Patient Name:_____ **DOB:** _____

1. Tallest Known Height: _____
2. Have you had any recent falls? Yes or No
    1. If yes, how many in the last year?: _____
3. Do you have a history of bone fracture? Yes or No
    1. If yes, which bone(s)?

        _____
        _____
        _____
        _____
        _____
4. Do you have a fear of falling? Yes or No
5. At what age did you start menses? _____
6. At what age did you complete menopause?_____
7. Have you had a hysterectomy? Yes or No
    1. If yes, what year?_____
    2. Did you have treatment with hormone replacement therapy?
8. Have you had a change in weight over the last year?
   Circle one: None Lost Gained
9. Do you have any dental procedures planned or needed to be done?
   Yes or No
10. When was your last Dental exam? Month_____ Year_____
11. Do you have a history of Jaw Pain?_____
12. Do you have problems with vision? Yes or No
13. When was your last eye exam? Month_____Year_____
14. Do you have cataracts? Yes or No
    1. Cataracts removed? Yes or No
        1. Year Removed_____
15. Do you have wheezing or shortness of breath? Yes or No

16.Are you a current or past smoker? Yes or No
    1. How long have/did you smoke? _____
17.Do you have problems with balance? Yes or No
18. Do you have an irregular heart rhythm? Yes or No

19. Do you have a history of:
    1. Chronic diarrhea? Yes or No
    2. Irritable Bowel Syndrome? Yes or No
    3. Poor gastrointestinal absorption? Yes or No
    4. Gastric bypass? Yes or No
    5. Peptic Ulcer Disease? Yes or No
    6. GERD? Yes or No
    7. Proton Pump Inhibitor use? (eg. nexium/omeprazole) Yes or No
        1. If yes, How many years?_____
20. Have you had any kidney stones? Yes or No

Potential Medical contributors to osteoporosis:
Do you have a history of:

21.Cancer? Yes or No
    1. If yes, where and when? _____
22. Current or recent radiation therapy? Yes or No
23.Thyroid Problems? Yes or No
24.Prolonged steroid Use? Yes or No
    1. If yes, how long? _____
25.Seizure Medication Use: Yes or No
26.Anticoagulants medication use? Yes or No
27.SSRI use (a type of antidepression/anxiety medications): Yes or No
28.Diabetes? Yes or No
29.Rheumatoid arthritis? Yes or No

- How do you feel like your dietary intake of calcium is?: (please circle)
    - Poor | Fair | Good | Very Good | Excellent
- What is your current oral supplementation of:
    - Calcium: _____ (mg/day)

- Vitamin D:_____(IU/day)