

New Patient Visit --Menopause and Osteoporosis Center

Name _____

Age _____

Referred by _____

Primary Care Physician _____

What is the reason for your visit today?

PAST MEDICAL HISTORY:

Circle medical history

- ◆ Heart attack, high blood pressure, stroke, TIA, blocked arteries
- ◆ Asthma, tuberculosis, emphysema, pneumonia
- ◆ Kidney stones, frequent urinary infections, other kidney disease
- ◆ Thyroid disease, Adrenal disease, pituitary disease
- ◆ High cholesterol, high triglycerides, diabetes, gastric bypass, celiac disease
- ◆ Anemia, blood clot, other blood disorder
- ◆ Osteoporosis, osteopenia, rheumatoid arthritis, osteoarthritis, fibromyalgia, lupus
- ◆ Breast biopsy, breast cancer, breast lump
- ◆ Other cancer: _____
- ◆ Abnormal pap smear, infertility, polycystic ovary disease
- ◆ Depression, anxiety disorder, bipolar disorder, postpartum depression, anorexia/bulimia

Hysterectomy? Yes No Ovaries removed? Both One No

Uterine ablation? Yes No

Prior use of menopausal hormones Yes No

Current use of menopausal hormones Yes No

Have you had a colonoscopy? Yes No Date _____

Reproductive History:

Age at first menstrual cycle_____ Date of last menstrual period_____

Number of pregnancies_____ if none, was this due to infertility? Yes No

Number of births_____ Your age at time of your first delivery_____

Miscarriages_____ Abortions_____

Are/were your menstrual cycles regular? Yes No

Are you sexually active? Yes No Method of contraception?_____

Date of last pap smear_____ History of abnormal pap?_____

Bone Health History:

- ◆ Date of last bone density scan_____ normal osteopenia osteoporosis
- ◆ Have you ever broken a bone? No Yes (If Yes, please complete table)

Bone broken	Please describe the circumstances	Age when this Occurred

- ◆ Have you taken steroids (Prednisone) for longer than 3 months? Yes No
- ◆ Has your mother or father fractured a hip? Yes No
- ◆ Family history of osteoporosis? _____
- ◆ Have you used any of the following medications? (Please circle)
 Dilantin Depo-Provera medication for acid reflux
- ◆ Do you consume dairy products like milk, yogurt or cheese daily? Yes No
 (please circle) 1-2 servings daily 3-4 servings daily 5 or more servings daily
- ◆ Daily calcium intake_____ mg per day
- ◆ Daily vitamin D intake_____units per day
- ◆ Are you having any dental problems that might require a tooth extraction?
- ◆ Have you been prescribed any of the following medications? (please circle)
 Fosamax Actonel Boniva Reclast Calcitonin Evista Forteo

Breast Health History:

Date of Last mammogram: _____ Breast implants Yes No
 Prior breast biopsy? No Yes results: _____
 Please circle relatives who have been diagnosed with breast cancer
 Mother age at time of diagnosis _____ Sister age of diagnosis _____
 Other relatives with history of breast cancer? _____
 Relatives with ovarian cancer? _____
 Relatives with colon cancer? _____

PAST SURGICAL HISTORY:

Name of surgery	Performed on which side?	Which year?

FAMILY HISTORY:

	<u>Living?</u>	<u>Medical Illnesses</u>
Mother	Yes No	Age _____
Father	Yes No	Age _____
Sister/Brother	Yes No	_____
Sister/Brother	Yes No	_____
Sister/Brother	Yes No	_____
Sister/Brother	Yes No	_____
Sister/Brother	Yes No	_____
Sister/Brother	Yes No	_____

LIFESTYLE AND SOCIAL HISTORY:

Single	Divorced	Children: Age _____ Sex _____ Illnesses: _____
Married	Widow	Age _____ Sex _____ Illnesses: _____
		Age _____ Sex _____ Illnesses: _____
		Age _____ Sex _____ Illnesses: _____

Education and Occupation: _____

Current Smoker? Yes No If yes, packs per day_____ Past smoker? Yes No

Alcohol (Beer,wine or liquor) Never 1-2 drinks/day more than 3/day

Caffeine: Never 1-2 drinks/day more than 3 drinks per day

Exercise: No Yes What type and how often?_____

MEDICATIONS:

List all medications that you take, including injections, pills, patches and creams:

REVIEW OF SYSTEMS:

Circle all that you are experiencing at the present time.

GENERAL: low energy, unexplained weight loss, weight gain.

HEENT: headaches, change in vision, decreased hearing

RESPIRATORY: cough, shortness of breath, chest congestion.

CARDIOVASCULAR: palpitations, chest pain, rapid heartbeat, leg swelling.

GASTROINTESTINAL: heartburn, diarrhea, constipation, nausea, abdominal pain

MUSCULOSKELETAL: back pain, joint pain, muscle pain, loss of height.

BREASTS: pain, lump, nipple discharge

GYN: irregular periods, heavy bleeding, cramping, vaginal dryness, discharge.

GENITOURINARY: urine leakage, frequent urination, bladder infections

SEXUAL: pain during sex, loss of interest in sex, inability to have orgasm.

ENDOCRINE: cold intolerance, dry skin, hot flashes, night sweats.

PSYCHIATRIC: mood swings, depression, anxiety, crying easily, irritability, insomnia.

NEUROLOGIC: dizziness, short-term memory loss, lack of concentration.