Western Orthopaedics FLS/Bone Health Clinic

New Patient Intake Form

Patient Name _____ MR_____

Date_____

What is your current height? _____

What was your tallest height? _____

Age? _____

What providers/doctors to do you see on a regular basis?

- Primary Care _____
- Endocrinology _____
- Rheumatology _____
- Other _____

	Yes	No	Comments
History of Osteoporosis			
Rheumatoid Arthritis			
Difficulty with Balance/Falls			
History of Fracture			
Tobacco/Alcohol use			___ packs per day/week _____ years _____ #alcoholic drinks/day
Prednisone or other steroid use			Duration _____ Dose _____
Family History of Osteoporosis			

	Yes	No	Comments
Cancer/Malignancy			Radiation _____ Chemotherapy _____ Resection _____
Pagets Disease (or other bone disease)			
Diabetes			Insulin Controlled _____ Recent A1C _____
Autoimmune Disease (Lupus, Crohns, IBD)			

	Yes	No	Comments
Eating Disorders (Anorexia, Bulimia, Excessive exercise)			
Gastroesophogeal Reflux (GERD)			
Malabsorption Syndrome			
Small Bowel Resection Surgery			
Gastric Bypass Surgery/Weight Loss Surgery			
Celiac Disease			

	Yes	No	Comments
Kidney Disease/Kidney Stones			
Hypercalcemia (too much calcium in your body)			

	Yes	No	Comments
Neurologic Disorders (MS, Parkinsons)			
Blood Disoders (anemia, bleeding disorders)			

For WOMEN:

Do you still have regular periods?

_____ yes ____ no

If YES, are they regular? ____ yes ____ no

If NO. Age of last menses _____

Have you had a hysterectomy?

____ yes ____ no

Do you/have you used Hormone Replacement Therapy?

Start date _____

End date _____

Name of Hormones_____

Dose_____

For MEN:

Do you have erectile dysfunction (ED) or low sex drive? _____ yes _____ no

Please specify:

_____

Do you, or have you used Hormone Replacement Therapy?

_____ yes _____ no

Start date _____

End date_____

For Office Use ONLY

Height _____ (inches)

Weight _____ (lbs)

BMI _____

T Score _____

FRAX score _____