



The Austin Diagnostic Clinic

ADC Menopause & Osteoporosis Center

Age: _____

Referred by: _____

Primary Care Doctor: _____

Reason for visit: _____

Past Medical History: Please check those that apply to your medical history. Provide date and details.

- Heart attack high blood pressure heart disease stroke blocked arteries rheumatic fever
- Seasonal allergies asthma tuberculosis positive TB skin test emphysema pneumonia
- Gallstones ulcer reflux colitis irritable bowel syndrome hepatitis
- Kidney stones frequent urinary infections other kidney disease
- Thyroid disorder adrenal disorder pituitary disorder high cholesterol high triglycerides diabetes
- Anemia other blood disorder blood clot migraines seizures
- Osteoporosis osteopenia rheumatoid arthritis osteoarthritis Fibromyalgia lupus
- Breast lump or cyst breast cancer other cancer abnormal PAP smear
- Depression anxiety disorder bipolar disease post-partum depression anorexia
- Other _____

Surgical History

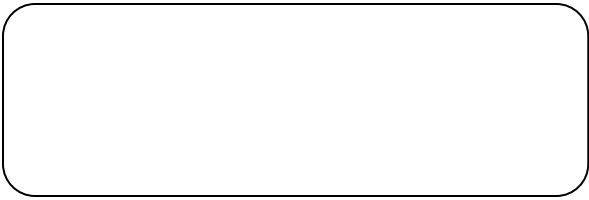
Have you had a hysterectomy? _____ If yes, were the ovaries removed? _____ Cervix? _____

List Past Surgeries:

Year:

List Past Surgeries:

Year:



Reproductive History

At what age did you begin having menstrual periods? _____

Number of pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____

Date of last menstrual period _____ Contraception Method: _____

Date of last PAP smear _____ Date of last mammogram: _____

Have you had a bone density test? _____ If yes, when? _____

Family Medical History (Please check and provide details)

	Living	Illnesses
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Sister/Brother	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Sister/Brother	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Sister/Brother	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Sister/Brother	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Do you have any relatives with the following: Breast cancer _____ Ovarian Cancer _____
Early heart disease _____ Osteoporosis _____ Colon Cancer _____

Lifestyle and Social History (Please check and provide details)

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

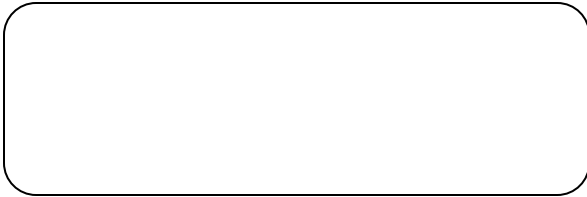
Education and Profession: _____

Exercise: _____

Current smoker? Yes No If yes, packs per day _____ Past smoker? Yes No

Alcoholic drinks per week _____ Cups of coffee per day _____ Sodas per day _____

Excessive life stress? Yes No _____



Review of Systems (Please check all symptoms that you are experiencing)

- General: low energy fever unexplained weight loss weight gain
- HEENT: headaches change in vision decreased hearing allergies
- Respiratory: shortness of breath cough chest congestion
- Cardiovascular: chest pain palpitations rapid heartbeat swelling
- GI: indigestion diarrhea constipation nausea vomiting abdominal pain
- Musculoskeletal: joint pain muscle pain back pain loss of height
- Breasts: pain lump fibrocystic condition nipple discharge
- GYN irregular periods heavy bleeding cramping vaginal dryness discharge
- Urological: frequent urination bladder infections urine leakage
- Sexual: pain during sex loss of interest in sex inability to have orgasm
- Skin: acne abnormal hair growth excessive hair shedding
- Endocrine: cold intolerance dry skin hot flashes night flashes
- Psychologic: mood swings PMS depression anxiety crying easily irritability insomnia
- Neurologic: dizziness short-term memory loss lack of concentration
- Other: _____