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
- Other: _____

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 taken any of the following medications? (please check)

  ☐Fosamax ☐Actonel ☐Boniva ☐Reclast ☐Calcitonin ☐Evista ☐Forteo ☐Prolia

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:

	Living?		**Medical Illnesses**
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
☐ Married ☐ Widow
☐ Partner

Children: Age _____ Sex____ Illnesses: _____
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.