ATLANTIC ORTHOPAEDIC SPECIALISTS
BONE HEALTH CLINIC

NAME: _____ DOB: _____ HEIGHT: _____

WEIGHT: _____ DRUG ALLERGIES: _____

LAST MENSTRUAL PERIOD:_____

Fracture/Fall/Osteoporosis History	**YES**	**NO**
Do you have a history of a bone fracture that resulted from a fall from a standing height?		
Have you fallen 1 or more times in the last year? Number of times _____?		
Have you ever been diagnosed with osteoporosis or low bone density?		
Have you taken medication for osteoporosis in the past?		
Medical History (have you ever had any of the following)	**YES**	**NO**
Diabetes?		
Rheumatoid Arthritis?		
Vitamin D deficiency?		
Neurologic disorder (Stroke, Parkinson's Disease, Multiple Sclerosis, etc.)		
Gastrointestinal disease (Reflux, esophagitis, irritable bowel disease, etc)?		
Breast or Prostate Cancer?		
Dental disease (gum disease, loose teeth, infections, bone loss)?		
In the last 6 months have you had a tooth pulled or dental implants placed?		
Do you have plans for a dental extraction or dental implants?		
Early menopause (natural or surgical before the age of 45)?		
Are you taking (or have you taken) steroids for more than 3 months?		
Testosterone or estrogen replacement therapy?		
Do you have a history of asthma or COPD?		
Nutrition History	**YES**	**NO**
Do you have any food allergies or intolerances?		
Do you take calcium supplements?		
Do you take Vitamin D supplements?		
Do you drink caffeine? How many cups of coffee per day _____? Soda _____?		
Exercise History	**YES**	**NO**
Do you walk, run, or lift weights? How many times per week _____?		
Do you have any conditions that restrict your ability to exercise?		
Lifestyle History	**YES**	**NO**
Are you a current smoker? How many years _____?		
Are you a previous smoker? How many years _____?		
Do you vape?		
Do you drink alcohol? How many drinks per day _____? What type _____?		
Family Medical History	**YES**	**NO**
Do you have parent or sibling diagnosed with osteoporosis?		
Have either your parents (or siblings) broken a bone after falling from a standing height?		

Please Estimate Your Daily Amount of Each	Number of Servings Per Day
Cow's Milk	8 oz glasses _____
Nondairy Milk (soy, almond, oat)	8 oz glasses _____
Yogurt containers	Containers _____
Hard Cheese (4 ounce serving)	Servings _____
Ice Cream (4 ounce serving)	Servings _____

Medications or Supplements

Who is your primary care provider? Please Provide Contact Information
When was your last visit? _____ **PCP Name:** _____ **Phone Number:** _____ **Address:** _____

Preferred Pharmacy