LABEL

THE UNIVERSITY OF KANSAS PHYSICIANS

DIVISION OF METABOLISM, ENDOCRINOLOGY AND GENETICS

CRAY DIABETES CENTER, HIATT OSTEOPOROSIS CLINIC

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PERSONAL HEALTH HISTORY INFORMATION			
Name (Last, First, Middle)		**Date of Birth**	☐ **Female** ☐ **Male**
Reason for your visit:			

SOCIAL HISTORY				
Marital Status	☐ Single	☐ Partnered	☐ Separated	
	☐ Married	☐ Divorced	☐ Widowed	
Employment	☐ Occupation:		☐ Homemaker	☐ Student
	☐ Retired		☐ Disabled	☐ Unemployed
Tobacco	☐ NO – I do not smoke and have never smoked			
	☐ YES – I previously smoked but no longer smoke		Quit Date:	
			Previous # packs/day	
			Total years smoked	
	☐ YES – I am currently smoking		# packs/day	
			# years smoking	
	Do you use chewing tobacco? ☐YES ☐NO ☐QUIT Date _____			
Alcohol	☐ NO – I do not drink any alcohol			
	☐ YES – I previously drink but no longer drink alcohol		Quit Date	
			Type of alcohol	
			# drinks/week	
	☐ YES – I drink alcohol		Type of alcohol	
			# of drinks/week	

ALLERGIES: Allergies or Adverse Reactions to medication so or other substances – please list drug name w/ reaction	

MEDICATIONS: List your prescribed drugs, over-the-counter, vitamins and supplements OR BRING YOUR OWN CURRENT LIST

Name	Strength (20 mg, units, cc's)	Frequency (1x a day….)

FLIP OVER FOR ADDITIONAL QUESTIONS

PHARMACY: Please enter in the information regarding the pharmacy you would like prescriptions sent to	
Name:	**Address:**

Phone Number:	

MEDICAL HISTORY: Please list all your medical conditions and diagnoses below:	

SURGERIES		
Year	**Surgery**	**Hospital**

FAMILY HEALTH HISTORY (Please fill in for those members with whom you are familiar)			
Are you adopted ☐YES ☐NO IF YOU ARE ADOPTED, PLEASE REFER TO YOUR BIOLOGICAL PARENTS, IF KNOWN			
	Living/Deceased	**Age**	**Significant Health History**
Mother			
Father			
Please list any other significant medical conditions that run in any other family members here			

VACCINATIONS: Please list the date of your last vaccine for the following:			
Influenza (flu):		**Tetanus:**	
Pneumonia :		**Shingles :**	

Your Providers: Please enter the name of your following providers:	
Referring Physician:	
Primary Care Physician:	

Would you like access to the myChart website? ☐YES ☐NO

HOSPITALIZATIONS		
Year	**Reason**	**Hospital**

If you are an OSTEOPOROSIS patient, please take time to answer the following questions prior to your visit.

Fracture History
Please list any broken bones (Fractures) you have had: ☐None

Broken bone	Age	Cause of the break

Family History of Bone health
Did either of your parents have a hip fracture? ☐ Yes ☐ No
Do any family members have the diagnosis of osteoporosis? ☐ Yes ☐ No

History of Steroid Treatment
Have you ever required treatment with steroid medication such as prednisone, hydrocortisone, dexamethasone by tablet or injection? ☐ Yes ☐ No
If Yes, did treatment last for more than 3 months? ☐ Yes ☐ No
Describe you steroid treatment history:

History of other diseases known to effect bone health	
Please check any of the following disorders you have or have had in the past:	
☐ Hyperparathyroidism	☐ Parkinson's disease
☐ Cushing's syndrome	☐ Seizures
☐ Renal (Kidney) stone	☐ Alcohol disorder
☐ Rheumatoid Arthritis	☐ Frequent falls or poor balance.
☐ Crohn's disease or Ulcerative Colitis	☐ Celiac disease
☐ Multiple sclerosis	☐ Diabetes
☐ Low vitamin D	

Female History
What age did you have your first menstrual period? _____
Were your menstrual periods usually regular? ☐ Yes ☐ No
At what age was your last menstrual period? _____
Have you had a hysterectomy? ☐ Yes ☐ No If Yes ,what age and for what reason?
If you had a hysterectomy were your ovaries removed? ☐ Yes ☐ No
Have you taken estrogen replacement therapy after menopause? ☐ Yes ☐ No
If Yes, for how many years? _____
How many pregnancies have you had? _____ How many live births? _____

Male History
Did you go through puberty the same time as your peers? ☐ Yes ☐ No
Do you have a history of low testosterone? ☐ Yes ☐ No
Do you have any children? ☐ Yes ☐ No
Is your sex drive normal? ☐ Yes ☐ No
Do you have any trouble with erectile function? ☐ Yes ☐ No

FLIP OVER FOR ADDITIONAL QUESTIONS

Calcium Intake History
How many dairy servings do you average in a day? ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 (a dairy serving is 8 oz. (1 cup) of milk, 1.5 oz. of cheese, 8 oz. (1 cup) of yogurt)
Has this been an average most or your life? ☐ Yes ☐ No
Do you take calcium supplementation? ☐ Yes ☐ No If Yes, please check which:

Calcium Carbonate 500 mg (Os Cal, Caltrate, TUMS, etc) ☐ 1 ☐ 2 ☐ 3 ☐ 4 daily
Calcium Citrate 315 mg (Citracal or other brands) ☐ 1 ☐ 2 ☐ 3 ☐ 4 daily
Other: Type_____ ☐ 1 ☐ 2 ☐ 3 ☐ 4 daily

Exercise History

Please check the most appropriate category:

☐ I do not exercise regularly

☐ I exercise at least 30 min once a week

☐ I exercise for at least 30 min 2-3 times a week

☐ I exercise for at least 30 min 3-5 times per week

☐ I exercise more than 30 min at a time and more than 5 times per week.

If you exercise regularly what type of exercise do you do most often? _____

Balance and Fall History

Would you say your gait and balance are good? ☐ Yes ☐ No

Have you fallen down in the past 6 months? ☐ Yes ☐ No
If Yes, how many times?_____
Describe the situation that caused the fall._____

If your gait and balance are a problem would you like to visit with physical therapy for a gait assessment and therapy to prevent falling? ☐ Yes ☐ No

Dental Health

Do you have any loose or bothersome teeth? ☐ Yes ☐ No

Do you anticipate the need to have a tooth pulled or invasive type dental work? ☐ Yes ☐ No

When was the last time you saw your dentist? ☐ Yes ☐ No

Did the dentist have concerns about your oral health? ☐ Yes ☐ No

Osteoporosis Treatment History: (Please indicate the treatments you have taken prior to this time or are taking)

Check if currently or previously taken	Medication	Dates	Reason discontinued
☐	Estrogen therapy		
☐	Raloxifene (Evista)		
☐	Alendronate (Fosamax)		
☐	Risedronate (Actonel)		
☐	Ibandronate (Boniva) oral		
☐	Ibandronate (Boniva) IV		
☐	Zolendronate (Reclast) IV		
☐	Calcitonin (Miacalcin) nasal spray		
☐	Denosumab (Prolia)		

PLACE AN X IN ANY BOX NEXT TO A PROBLEM OR DISTRUBANCE YOU HAVE HAD IN THE PAST YEAR			
GENERAL HEALTH ☐ No problems	☐ Weight loss ☐ Night sweat ☐ Hot flashes	☐ Weight gain ☐ Heat sensitivity ☐ Cold sensitivity	☐ Loss of appetite ☐ Tire easily ☐ Weakness
SKIN/HAIR/NAILS ☐ No problems **Last foot exam: _____**	☐ Skin rash ☐ Excessive sweating ☐ Foot callus	☐ Dry Skin ☐ Skin itching ☐ Foot sore or ulcer	☐ Change in hair/nails ☐ Non healing wounds ☐ Excessive facial hair
EYES ☐ No Problems	**Date of last eye exam:** **_____**	☐ Eye redness ☐ Peripheral vision loss	☐ Eye pain ☐ Double vision
EARS/NOSE ☐ No problems	☐ Ringing in the ears ☐ Decrease in hearing	☐ Discharge from ears ☐ Loss/lack of smell	☐ Ear pain
MOUTH ☐ No problems	**Date of last dentist visit:** **_____**	☐ Bleeding gums ☐ Dental infection ☐ Recent tooth extraction	☐ Dental implants ☐ Dental surgery
NECK ☐ No problems	☐ Neck swelling or lumps ☐ Persistent hoarseness	☐ Neck stiffness ☐ Food getting stuck	☐ Sore throat
CHEST ☐ No problems	☐ Frequent cough ☐ Bloody sputum	☐ Wheezing ☐ Painful breathing	☐ Shortness of breath ☐ Chest pain/discomfort
HEART ☐ No problems	☐ Swelling of hands/feet ☐ Blood clots	☐ Palpitations ☐ Enlarged veins	☐ Irregular heartbeat
STOMACH/BOWELS ☐ No problems	☐ Abdominal cramping ☐ Chronic constipation ☐ Heartburn	☐ Nausea/Vomiting ☐ Rectal bleeding ☐ Gastric reflux	☐ Chronic diarrhea ☐ Black tarry stools
URINARY ☐ No problems	☐ Frequent urination ☐ Leakage of urine	☐ Increase in thirst ☐ Difficulty urinating	☐ Painful urination ☐ Kidney stone history
GENITAL ☐ No problems	☐ Lack of sex drive	☐ Painful sex	
NEURO ☐ No problems	☐ Numbness/tingling ☐ Memory loss ☐ Loss of balance	☐ Tremors ☐ Dizziness ☐ Trouble with anxiety	☐ Headaches ☐ Depression ☐ Sleep problems/changes
MUSCLES/BONE/JOINTS ☐ No problems	☐ Back pain ☐ Muscle cramps/spasms	☐ Joint pain or stiffness ☐ Swollen joints	☐ History of broken bones:_____ _____
MEN ONLY ☐ No problems	☐ Difficulty with erection	☐ Testicle lump/pain	☐ Penis discharge
WOMEN ONLY ☐ No problems	☐ Period absent ☐ Menstrual pain/cramps ☐ Breast discharge ☐ Menopause Age: _____	☐ Irregular menstrual cycle ☐ Breast Pain Date of last mammogram: _____	☐ Heavy menstrual flow ☐ Hormone replacement therapy # of pregnancies: _____ # of live births: _____
MENTAL HEALTH ☐ No problems	☐ Do you often feel overwhelmed by your disease?	☐ Are there very few things that make you happy?	If so, Explain:

Anything else you would like your provider to know: