Fort Walton Beach
*1034 Mar Walt Drive
Fort Walton Beach,
FL 32547*

Destin
*36474C Emerald
Coast Parkway, Suite 3101
Destin, FL 32541*

Niceville
*554-D Twin
Cities Boulevard
Niceville, FL 32578*

Panama City
*1827 Harrison Avenue
Panama City, FL 32405*

Crestview
*5300 South Ferdon Boulevard
Crestview, FL 32536*

P 850-863-2153 F 850-863-8085 www.orthoassociates.net

OA Osteoporosis Clinic – New Patient Questionnaire

Welcome to our clinic! Please complete this form along with a list of your current medications and supplements (or bring all your medication bottles) to your appointment.

Patient Name: ______________________________ Date of Birth: __________ Age: ________

Have you broken any bones after age 50? YES / NO

Bone	Date	How did it happen (ex. car accident, fall, etc.)?

Prior diagnosis of osteoporosis or osteopenia? YES / NO

When was your last DEXA (bone density) scan? Date: _______________
T Score: _____________

Have you taken any of these medications (now or in the past)?

Medication	Yes	No	Dates: _____ to ______	If you have stopped, why?
Alendronate/Fosamax				
Risedronate/Actonel				
Ibandronate/Boniva				
Zoledronate/Reclast				
Denosumab/Prolia				
Teriparatide/Forteo				
Raloxifene/Evista				
Calcitonin/Fortical or Miacalcin				
Estrogen				

Do you take calcium supplements? YES / NO

Do you take vitamin D supplements? YES / NO

Do you take oral steroids (ex. Prednisone) regularly? YES / NO

Women's Reproductive History:
Do you still have periods? YES / NO
If yes, they are: REGULAR/IRREGULAR

Age or date of last menstrual period: __________________

Have you used hormone replacement/estrogen therapy? YES / NO
Date: ________ to _________

Prior Surgeries:
Have you had any of the following gynecologic surgeries?
Bilateral oophorectomy (removal of both ovaries) YES / NO Date:________
Total hysterectomy including removal of both ovaries YES / NO Date:________

Have you had a gastric bypass? YES / NO Date: ____________

Other surgeries: ____
____

Personal Medical History:

Condition	Yes	No	Do you see a specialist for this?
Parathyroid disease			
Thyroid disease			
Kidney disease			
GERD/Reflux			
Esophageal disorder			
Stomach ulcers			
Heart condition Specify:______________________			
Stroke			
Osteoporosis			
Celiac disease			
Cancer (type __________________)			

For patients with a history of cancer:
Year of diagnosis: ________
Circle the following that you received: Surgery / Radiation / Chemotherapy

If breast cancer:
Did you receive Tamoxifen? YES / NO Date: ________ to _________

Did you receive Aromatase inhibitor? YES / NO Date: ________ to _________

Family History:
Does osteoporosis run in your family? Mother / Father / Other(s)_______________
Has either of your parents broken a hip? Mother / Father

Social History:
Do you exercise regularly? YES / NO
_______ minutes per day ______ days per week

Do you use a: Cane / Walker / Wheelchair / Other

Have you fallen within the last year? YES / NO

Do you smoke? Yes / Former / Never

______ packs/day x _____ years. If quit, when? _________

Alcohol: _____ drinks per week

Drugs: Marijuana / Cocaine / Opiates / Other

Review of Systems: *Are you experiencing any of the following:*

fever/ chills/ fatigue/ weight loss/ frequent falls

rashes/ wounds/ itching

vision changes/ hearing changes

chest pain/ palpitations/ pain with breathing

cough/ wheezing/ shortness of breath

nausea/ vomiting/ diarrhea/ constipation/ heartburn

pain with urination / incontinence

leg swelling / calf pain/ easy bruising

joint pain / muscle aching / back pain / stiffness

headaches / numbness and tingling / weakness

ANYTHING ELSE WE SHOULD KNOW ABOUT YOU?

____

____

____

____ _______________

Patient Signature (or guardian/representative) **Date**