Healthy Bone Clinic Registration

Name: _____ **DOB:** _____ **M / F:** _____

Primary Doctor: _____ Ht/Wt: _____/_____

Pregnant?: Y / N Menopause Age: _____

Have you had a Bone density test in past 2 years?: Y / N If so, where: _____

In past 7 days, have you had a nuclear medicine isotope study? Y / N

Or a test using iodine or barium? Y / N

Do you currently take calcium or vitamin D supplements? Y / N

Are you currently a cigarette smoker? Y / N

If no, did you ever smoke? Y / N # of years _____

Have you ever been treated with any of the following medications?

Medication	Ever?	Currently?	If current, how long?
Hormone replacement therapy (estrogen)			
Tamoxifen			
Raloxifene (Evista)			
Testosterone			
Alendronate (Fosamax)			
Risedronate (Actonel)			
IV Reclast			
Boniva			
Calcitonin (Miacalcin nasal spray)			
PTH (Forteo)			
Prolia			

Current Medications

Allergies: _____

_____

Pertinent Medical History

Previous Surgeries

Family History

Review of systems. Check all that apply and please explain "yes" answers.

Symptom	Yes	No	Explanation
Fever/chills/night sweats			
Weight loss/gain last 6 months			
Vision changes			
Dental problems			
Shortness of breath/cough			
Chest pain/irregular heartbeat			
Leg swelling			
Heartburn/abdominal pain			
Bloody or black stools			
Urinary problems or infections			
Swelling or painful joints			
Back or neck problems			
Numbness/tingling			
Weakness/paralysis			
Rashes/skin ulcers			
Depression/psychiatric concerns			
Bleeding/bruising			
Any other health concern			

_____ _____

Patient Signature **Date**