**SOUTHERN MD ORTHOPAEDIC & SPORTS MEDICINE CENTER**
**23000 MOAKLEY STREET, SUITE 102, LEONARDTOWN, MD 20650**
**301-475-5555**

## PATIENT HISTORY QUESTIONNAIRE

| | | | |
|---|---|---|---|
| **Name:** | _____ | **Today's Date:** | _____ |
| **Patient ID:** | _____ | **Sex:** | ○F ○M |
| **Current Height: (in)** | _____ | **Date of Birth:** | _____ |
| **Weight: (lb)** | _____ | **Referring Physician:** | _____ |
| **Menopause Age:** | _____ | **Ethnicity:** | _____ |

1. Have you ever taken any of the following medications?
   - ☐ Fosomax ☐ Actonel ☐ Corticosteroids (i.e. Prednisone, etc.)
   - ☐ Evista ☐ Estrogen ☐ Miacalcin
   - ☐ Forteo ☐ Calcium ☐ Reclast
   - ☐ Other – Please specify: _____

2. At what age did your period start? _____

3. How many children do you have? _____

4. What was your maximum height (inches)? _____

5. Do you have a family history of osteoporosis? ○ Yes ○ No

6. Do you perform weight bearing exercise regularly? (i.e. walking) ○ Yes ○ No

7. Do you regularly consume dairy products? ○ Yes ○ No

8. Have you ever missed your period for more than 6 months in a row (not including pregnancy or menopause)? ○ Yes ○ No

9. Have you had any fractures during your adult life which did not result from significant trauma (i.e. auto accident)? ○ Yes ○ No

10. Did either of your parents have a fractured hip? ○ Yes ○ No

11. Do you smoke? ○ Yes ○ No

12. Do you drink more than 2 alcoholic drinks daily? ○ Yes ○ No

13. Do you drink caffeinated beverages? ○ Yes ○ No

14. Do you have any of the following medical conditions?
   - ☐ Hyperthyroidism ☐ Hyperparathroidism ☐ Rheumatoid Arthritis
   - ☐ Hysterectomy ☐ Asthma or Emphysema ☐ Seizure Disorder
   - ☐ Cancer ☐ Anorexia or Bulimia
   - ☐ Other – Please specify _____