MEDICAL INFORMATION

Name ____ Date __________________________________
HOW LONG AT CURRENT JOB? ___________HAVE YOU BEEN SEEN HERE BEFORE? __YES __NO

1.) Why are you seeing the doctor today? (example foot pain, etc.) _______________________________

____

2.) _______Right _______ Left

3.) How long have you had this problem? ____

4.) Have you seen another doctor for this problem? _____________________________________

If yes, what doctor? _____________________________________

5.) Did you go to the emergency room for this problem? ______Yes ______No

6.) Have you had any test? Circle: XRAYS, MRI or CT. Did you bring them with you today? ____Yes ____No
FOR XRAY PURPOSES, ARE YOU PREGNANT? ______YES ______NO

7.) Is patient in a nursing home, if yes what facility? ____

OSTEOPOROSIS SCREENING

AGE______WEIGHT_________HEIGHT ___________HEIGHT TODAY _____________
HAVE YOU HAD A BONE DENSITY TEST IN THE LAST 2 YEARS? ______Y ______N
POST MENOPAUSAL ______Y ______N
FAMILY HISTORY OF OSTEOPOROSIS /BONE FRACTURE ______Y______N
HAVE YOU HAD A FRACTURED WRIST/HIP/VERTEBRAE ______Y______N
DO YOU HAVE A HISTORY OF PROSTATE CANCER ______Y______N
DO YOU SMOKE ______Y______N FOR HOW LONG? _________________________
DO YOU DRINK ALCOHOL ______Y ______N
DO YOU TAKE CALCIUM ______Y ______N
DO YOU EXERCISE REGULARLY______Y ______N

SIGNATURE____

ROOM # __________