LAKE POINTE
HEALTH NETWORK

LPXNA002

Please complete the following questions to the best of your ability. If you are unsure how to answer, leave the space blank and we will help with the answer when you are seen at this facility. All answers will be kept in strict confidence and treated as information in your medical records.

Name:____

Street address: ____

City: ____________________________________ State: __________ Zip __________

Date of birth ____

Race: Afro-American_____ Caucasian_____ Native American_____ Oriental_____ Other_____

Sex: Male_____ Female_____

Have you fractured any bones during your adult life?_________________________

Is there a family history of osteoporosis? __________________________________

Has either parent ever sustained a hip fracture? _____________________________

Do you smoke more than ½ pack of cigarettes per day?________________________

Have you smoked in the past? ____

How many servings of dairy products do you consume each day? _______________

Do you take a calcium supplement daily?___________________________________

Do you exercise three times per week? ____________________________________

Do you drink more than two alcoholic drinks per day?_________________________

Have you taken any of the following medications:
Steroids (Predisone, Cortisone, etc) ______________________________________

Thyroid medication:____

Anticonvulsants (for seizures, epilepsy) ___________________________________

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Have you had any of the following conditions:

Partial or complete paralysis ______________________
Hyperthyroidism (overactive thyroid) ______________________
Kidney disease ______________________
Rheumatoid arthritis ______________________
Other arthritis ______________________
Part of stomach removed ______________________
Intestinal or bowel disease ______________________
Height:__________ Inches:__________ Weight__________

REMAINING QUESTIONS FOR FEMALES ONLY

Have you gone through menopause? ______________________
Did your menopause occur before age 45? ______________________
Do you have amenorrhea (never stared periods or ended at a young age? ______________________
Do you now take hormones (Premarin, estrogen, etc.) ______________________
Have you taken hormones (not including birth control pills) in the past?______________________
Have you had any of the following side effects from hormones:
Breast soreness ______________________
Heavy periods or other bleeding ______________________
Headaches ______________________
Weight gain or fluid buildup ______________________
Other______________________

How long have you taken or did you take hormones? ______________________
Have you had any of the following conditions:
Hysterectomy ______________________
Ovaries removed ______________________
Blood clots ______________________
If yes, were you on hormones at the time ______________________
Breast cancer ______________________
Family history of breast cancer ______________________
Cancer of the uterus ______________________

PRINT PATIENT NAME	PATIENT SIGNATURE	DATE	TIME