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# FRACTURE LIAISON SERVICE (FLS) BY R&O

**NEW PATIENT HISTORY FORM** ***PLEASE USE BLACK OR BLUE INK ONLY***

Patient Name _____
Last First Middle Initial Maiden

Preferred name if different than above_____ Birthdate: _____/_____/_____ Age:_____

Address_____ Social Security #_____

City_____ State_____ Zip Code_____

Telephone: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Email Address:_____ Preferred Method of Contact: Home Work Cell

**Sex:** ☐ Male ☐ Female **Are you:** ☐ Right Hand Dominant ☐ Left Hand Dominant ☐ Ambidextrous

**Primary Language** (circle one): English Other_____ **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

**Race:** ☐American Indian or Alaska Native ☐Asian ☐ Black or African American ☐White ☐Native Hawaiian or Other Pacific Islander

**MARITAL STATUS:** ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

**EMERGENCY CONTACT:** 1) Name_____ Relationship_____

Phone Number(s)_____

2) Name_____ Relationship_____

Phone Number(s)_____

**REFERRAL:** Referred here by: ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Heath Professional

Name of person making referral_____

Primary Care Physician (PCP)_____

Do you have an orthopedic surgeon? ☐ Yes ☐ No If yes, Name:_____

Have you been treated for osteoporosis? ☐ Yes ☐ No If yes, where/by who?_____

**PREFERRED PHARMACY:**

Local_____Location_____

Mail Order_____Location_____

Patient's Name_____ Date_____

**PREVIOUS OPERATIONS**

| Type of Surgery | Year | Reason |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |

**PREVIOUS FRACTURES**

| Location of Fracture/Type | Year or Age at Fracture | Reason |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |

**FAMILY HISTORY**

Do you know of any **blood relative** who has or had: (check and give relationship)

☐ Alcoholism_____ ☐ Diabetes_____ ☐ Hip fracture_____ ☐ Psoriasis_____

☐ Blood clots_____ ☐ Dowager's hump_____ ☐ Hypertension_____ ☐ Stroke_____

☐ Cancer_____ ☐ Elevated urine calcium_____ ☐ Kidney stones_____ ☐ Thyroid disorder_____

☐ Celiac Sprue_____ ☐ Epilepsy_____ ☐ Leukemia_____

☐ Colitis_____ ☐ Heart disease_____ ☐ Osteoporosis_____

Any other conditions that run in your family?_____

**SOCIAL HISTORY**

Do you drink caffeinated beverages? ☐ Yes ☐ No
Cups/glasses per day_____

Do you smoke? ☐ Yes ☐ No ☐ Past smoker

When did you quit?_____ How many packs per day?_____

How many cigarettes per day?_____

Do you drink alcohol? ☐ Yes ☐ No # drinks/week_____

Do you exercise regularly? ☐ Yes ☐ No

Type_____

Amount per week_____

Do you consume dairy products? ☐ Yes ☐ No

Average number of servings per day_____
Average number of servings per week_____

**PAST MEDICAL HISTORY**

Do **you** now or have **you** ever had: (check if "yes")

☐ Alcoholism ☐ Diabetes ☐ Liver disease

☐ Anemia ☐ Eating disorder ☐ Osteoporosis

☐ Blood clots ☐ Gastric bypass surgery ☐ Rheumatoid arthritis

☐ Cancer ☐ Heartburn

☐ Celiac Sprue ☐ HIV/AIDS ☐ Seizure disorder

☐ Colitis ☐ Kidney disease ☐ Stomach ulcers

☐ Cushing's disease ☐ Kidney stones ☐ Thyroid disorder

☐ Lactose intolerance

Other significant illness (please list)_____

Medication History: ☐ Steroids ☐ Cortisone ☐ Depo Provera
Describe: _____

Patient's Name_____ Date_____

**ALLERGIES (medications, latex, food, etc.)**

| Allergic to | Reaction |
|---|---|
| **1.** | |
| **2.** | |
| **3.** | |
| **4.** | |
| **5.** | |

**PRESENT MEDICATIONS** List all medications you are taking. (Include multiple vitamins, antacids, calcium, Vitamin D, supplements)

| Name of Drug | Dose (include strength & number of pills per day) | How long have you taken this medication? | Please check: Helped? | | |
|---|---|---|---|---|---|
| | | | A Lot | Some | Not at All |
| **1.** | | | ☐ | ☐ | ☐ |
| **2.** | | | ☐ | ☐ | ☐ |
| **3.** | | | ☐ | ☐ | ☐ |
| **4.** | | | ☐ | ☐ | ☐ |
| **5.** | | | ☐ | ☐ | ☐ |
| **6.** | | | ☐ | ☐ | ☐ |
| **7.** | | | ☐ | ☐ | ☐ |
| **8.** | | | ☐ | ☐ | ☐ |

**PAST OSTEOPOROSIS MEDICATIONS (**Please review this list of medications. As accurately as possible, try to remember which medications you have taken, ***how long*** you were taking the medication, the ***results*** of taking the medication and list any ***reactions*** you may have had. Record your comments in the spaces provided.)

| Drug names/Dosage<br>Generic (Brand) Names | Length of time | Please check: Helped? | | | Reactions |
|---|---|---|---|---|---|
| | | A Lot | Some | Not at All | |
| **OSTEOPOROSIS MEDS** | | | | | |
| **Alendronate (Fosamax)** | | ☐ | ☐ | ☐ | |
| **Ibandronate (Boniva)** | | ☐ | ☐ | ☐ | |
| **Risedronate (Actonel)** | | ☐ | ☐ | ☐ | |
| **Zoledronic Acid (Reclast, Zometa)** | | ☐ | ☐ | ☐ | |
| **Pamidronate (Aredia)** | | ☐ | ☐ | ☐ | |
| **Teriparatide (Forteo)** | | ☐ | ☐ | ☐ | |
| **Denosumab (Prolia)** | | ☐ | ☐ | ☐ | |
| **Raloxifene (Evista)** | | ☐ | ☐ | ☐ | |
| **Estrogen or Hormone Replacement Therapy (HRT)** | | ☐ | ☐ | ☐ | |
| **Calcitonin (Miacalcin)** | | ☐ | ☐ | ☐ | |

**Date of last bone density test (DXA) _____/_____/_____ Location**_____

Patient's Name_____ Date_____

## SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you. Thank you!

**Constitutional**
- ☐ Falls
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Recent weight gain Amount_____
- ☐ Recent weight loss Amount_____
- ☐ Weakness

**Eyes**
- ☐ Double or blurred vision
- ☐ Dry eyes
- ☐ Eye pain
- ☐ Eye redness
- ☐ Low vision

**Ear-Nose-Mouth-Throat**
- ☐ Bleeding gums
- ☐ Difficulty swallowing
- ☐ Dry mouth
- ☐ Hoarseness
- ☐ Runny nose
- ☐ Sinus trouble
- ☐ Sores in mouth or nose

**Cardiovascular**
- ☐ Chest pain
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat

**Respiratory**
- ☐ Cough
- ☐ Difficulty in breathing at night
- ☐ Pain with breathing
- ☐ Shortness of breath
- ☐ Snoring
- ☐ Swollen legs or feet

**Gastrointestinal**
- ☐ Black stools
- ☐ Blood in stools
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Stomach pain
- ☐ Vomiting

**Genitourinary**
- ☐ Blood in urine
- ☐ Difficult urination
- ☐ Getting up at night to pass urine
- ☐ Pain or burning on urination
- ☐ Vaginal dryness

**Musculoskeletal**
- ☐ Falls
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Morning stiffness
- ☐ Muscle tenderness
- ☐ Muscle weakness

**Integumentary (skin)**
- ☐ Easy bruising
- ☐ Nodules/bumps
- ☐ Pigment changes to skin
- ☐ Psoriasis
- ☐ Rash

**Neurological**
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory loss
- ☐ Muscle spasms
- ☐ Numbness or tingling
- ☐ Restless legs

**Psychiatric**
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Excessive worries

**Hematologic/Lymphatic**
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Swollen glands
- ☐ Tender glands

***For Women Only:***

Approx. age of menopause_____

Did you have surgical menopause?
☐ Yes ☐ No

Number of pregnancies_____

Number of miscarriages_____

History of irregular periods?
☐ Yes ☐ No

Bleeding after menopause?
☐ Yes ☐ No

Have you ever taken estrogen?
☐ Yes ☐ No

If so, for how long?_____

Patient's Name_____ Date_____