R&O RHEUMATOLOGY&OSTEOPOROSIS services p.c.

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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 ☐ Seizure disorder

☐ Celiac Sprue ☐ HIV/AIDS ☐ Stomach ulcers

☐ Colitis ☐ Kidney disease ☐ Thyroid disorder

☐ Cushing's disease ☐ Kidney stones ☐ 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 Generic (Brand) Names	Length of time	Please check: Helped? A Lot	Some	Not at All	Reactions
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______________________