Personal & Family History Review

Please answer all questions

Place sticker here

☐ Dr. A. Nattiv ☐ Dr. D. Kado ☐ Dr. J. Adams

LAST NAME	FIRST NAME	BIRTHDATE (MM/DD/YEAR)	AGE	CURRENT OCCUPATION	NO OF YEARS AT THIS OCCUPATION

ARE YOU ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

Past medical history

PLEASE LIST ALL KNOWN MEDICAL PROBLEMS /DIAGNOSIS THAT YOU HAVE RECEIVED BY A MEDICAL DOCTOR AND APPROXIMATE YEAR OF DIAGNOSIS

Surgery record

DATE	NAME OF OPERATION	REASON FOR OPERATION	SURGEON

Family history: Please answer each question as completely as you can. If you are not sure, put a question mark (?)

RELATIONSHIP	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE OF DEATH
FATHER				
MOTHER				
BROTHER(S)				
SISTER(S)				
HUSBAND OR WIFE				
CHILDREN				

Personal & Family History Review

Please answer all questions

Indicate which blood relative (parent, brother, sister, aunt, uncle, grandparent, child) have had the following:

CONDITION	RELATIONSHIP		CONDITION	RELATIONSHIP
STROKES, HIGH BLOOD PRESSURE, HEART DISEASE, HEART ATTACK			CANCER OR LEUKEMIA	
NERVOUS BREAKDOWN OR OTHER MENTAL DISEASE			GOUT	
KIDNEY TROUBLE			ALCOHOLISM OR DRUG ABUSE	
DIABETES			STOMACH OR DUODENAL ULCER	
ASTHMA, HIVES, ECZEMA OR HAY FEVER			THYROID TROUBLE OR GOITER	
LIVER DISEASE TUBERCULOSIS OR OTHER			INTESTINAL PROBLEM	
OSTEOPOROSIS OR HISTORY OF FRACTURE			OTHER	

Medication Record: Prescription Medications

NAME OF DRUG	STRENGTH & FREQUENCY	PRESCRIBING PHYSICIAN	DATE STARTED	DATE STOPPED

Vitamins, Minerals and Supplements (including calcium and vitamin D)

NAME	STRENGTH & FREQUENCY	DATE STARTED	DATE STOPPED

List all medications to which you are allergic or had a bad reaction:

Personal & Family History Review

Please answer all questions

Food Record

Day 1	Day 2	Day 3
Breakfast	Breakfast	Breakfast
Between Meals	Between Meals	Between Meals
Lunch	Lunch	Lunch
Between Meals	Between Meals	Between Meals
Dinner	Dinner	Dinner

An inventory of what you eat and drink, how much you eat and drink, and how your food is prepared is a valuable tool in preparing a personalized program to improve and/or maintain the strength of your bones. Please take the time to inventory what you ate recently over a representative three-day period. List each food and drink and the approximate amount of each in terms of serving size (i.e: cups, ounces, tablespoons). Please pay particular attention to dairy products.

Personal & Family History Review

Please answer all questions

	Yes	No
1. Were you born with any defect or condition?	☐	☐
a. If **YES**, what? _____		
2. Has a doctor said you had:		
a. Heart disease?	☐	☐
b. A heart murmur?	☐	☐
c. An enlarged heart?	☐	☐
d. High blood pressure?	☐	☐
e. A heart attack? (coronary, angina, infarct)	☐	☐
f. An abnormal electrocardiogram? (ECG, EKG)	☐	☐
3. Has a doctor said you had:		
a. A lung or pulmonary disorder?	☐	☐
b. Asthma?	☐	☐
c. Bronchitis or pneumonia?	☐	☐
d. Close contact with anyone who had TB?	☐	☐
e. A TB skin test which was positive?	☐	☐
f. A TB skin test which was negative?	☐	☐
g. An abnormal or positive chest x-ray?	☐	☐
h. Pulmonary emphysema?	☐	☐
4. Has a doctor said you had:		
a. Gastric reflux (hiatal hernia)?	☐	☐
b. Liver disease (such as hepatitis)?	☐	☐
c. Stomach, duodenal or peptic ulcer?	☐	☐
d. Colon, bowel or intestinal disease?	☐	☐
5. Have you had:		
a. Kidney disease (such as nephritis)?	☐	☐
b. Kidney or bladder infection?	☐	☐
c. Kidney or bladder stones?	☐	☐
6. Have you had:		
a. Cancer or a tumor?	☐	☐
b. If yes, what kind of tumor? _____		

Personal & Family History Review

Please answer all questions

	Yes	No
7. Have you had:		
a. Arthritis?	☐	☐
b. Rheumatism?	☐	☐
c. Gout?	☐	☐
8. Has a doctor said you had and an eating disorder or disordered eating?	☐	☐

If YES, was it:

a. Anorexia nervosa? ☐

b. Bulimia nervosa? ☐

c. Eating disorder not otherwise specified (EDNOS)? ☐

d. Disordered eating (without one of the diagnoses above in a-c)? ☐

At what age and for how long did you have this diagnosis? _____

9. What was your approximate highest and lowest weight in the last 12 months?
Highest (lbs)_____ Lowest (lbs.)_____

	Yes	No
10. Have you experienced any height loss?	☐	☐
11. If so, how many inches? _____		
12. Have you ever had any broken bones (fractures – including stress fractures)?	☐	☐

If Yes, please list which bone(s) were broken, what year this occurred and how the injury happened:

_____

_____

Did you ever have a serious illness that did not involve a surgical operation?	☐	☐

If YES, fill in below: (If you were in a hospital, state which one)

Condition or illness	Year/Hospital

Personal & Family History Review

Please answer all questions

REVIEW OF SYSTEMS:

	Yes	No
Have you often had:		
Frequent, bad headaches?	☐	☐
Dizzy spells so bad the room seemed to spin around?	☐	☐
Convulsions (fits)?	☐	☐
Fainting (black out, unconscious) spells?	☐	☐
Spells of weakness or paralysis of arms or legs?	☐	☐
Head injuries bad enough to knock you out?	☐	☐
Do you wear glasses?	☐	☐
Have you had any:		
Blurring of eyesight lasting over a few minutes?	☐	☐
Bad pain in the eyeball?	☐	☐
Spells of seeing double?	☐	☐
Serious infection or bad injury to the eye?	☐	☐
Have you had:		
Drainage from or bad injury to the ear?	☐	☐
Loss of hearing which has not improved?	☐	☐
Noises (buzzing or ringing) in the ear?	☐	☐
Nose bleeds not caused by an injury or a cold?	☐	☐
Bleeding gums?	☐	☐
A hoarse voice that has not improved?	☐	☐
Have you had shortness of breath:		
With your usual work or activity?	☐	☐
That makes you stop after climbing 10-14 steps?	☐	☐
That awakened you from sleep?	☐	☐
With wheezing (whistling) breathing?	☐	☐
Often when sitting still?	☐	☐
Have you had repeated pain (or pressure or tight feeling) in your chest:		
In the middle under the breast bone?	☐	☐

	Yes	No
On one or both sides?	☐	☐
When you were sitting still?	☐	☐
When you were angry or excited?	☐	☐
After a big meal?	☐	☐
That awakened you from sleep?	☐	☐
When you walked fast or uphill and left after a few minutes rest?	☐	☐
That forced you to stop walking?	☐	☐
That lasted more than ten minutes?	☐	☐
In the past 6 months have you often had:		
Thumping or racing of the heart?	☐	☐
Painless swelling of only one foot or ankle?	☐	☐
Painless swelling of both feet or both ankles?	☐	☐
Painful swelling in either leg?	☐	☐
Cramps in your legs which awakened you?	☐	☐
Have you often had pain in your legs that forced you to stop walking and left after a few minutes rest?	☐	☐
Have you:		
Had a cough almost every day?	☐	☐
Coughed up yellow or green sputum (phlegm) almost every day?	☐	☐
Coughed up any blood?	☐	☐
Have you often had:		
Trouble swallowing solid foods?	☐	☐
Trouble swallowing liquids?	☐	☐
Heartburn?	☐	☐
Indigestion?	☐	☐
Had nausea (sick to stomach) or vomiting?	☐	☐
Been troubled by excessive gas or bloating?	☐	☐

	Yes	No
Have your bowel movements often been:		
Loose and watery?	☐	☐
Dry and hard like marbles?	☐	☐
Mixed with mucus or slimy matter?	☐	☐
Thin and narrow like a pencil or ribbon?	☐	☐
Have you had:		
Burning or pain when urinating (passing water)?	☐	☐
Loss of control of the bladder?	☐	☐
Trouble starting urination?	☐	☐
Urine which was bloody or color of black coffee	☐	☐
13. Do you always have to get up from sleep to urinate (pass water) more than once?	☐	☐
14. Do you urinate (pass water) frequently during the day?	☐	☐
15. Have you experienced a fall in the past year? (If no, skip to question 44)	☐	☐
16. Did you injure yourself as a result of the fall(s)?	☐	☐

If **YES**, what was the nature of the injury?

_____

_____

_____

17. How many falls have you experienced in the past 3 months? _____		
18. Do you have a fear of falling?	☐	☐

FEMALE ONLY (IF MALE, CONTINUE WITH QUESTION #56)

19. How old were you :

When monthly menstrual periods began? _____

20. Are you still having monthly menstrual periods?	☐	☐
If **YES**, in the past year have you had any:		
Bleeding between your monthly periods or very heavy bleeding with your periods?	☐	☐
Swelling of feet before or with periods?	☐	☐
If **NO**, (and you have not gone through menopause) have you ever skipped your period for 3 months or more in a row?	☐	☐

21. What is the typical length of your menstrual cycle (from the start of one menstrual cycle to the start of another)?_____

	Yes	No
22. Are you now pregnant?	☐	☐
23. If you are no longer having periods, have you had any bleeding from the vagina in the past year?	☐	☐
24. Have you had:		
Discharge from the breast nipple?	☐	☐
Heavy discharge from the vagina (privates)?	☐	☐
25. In the past year have you:		
Taken pills to control your periods or to prevent pregnancy?	☐	☐
Used other methods of contraception?	☐	☐
Had any miscarriages?	☐	☐
Had any childbirths?	☐	☐

26. How many pregnancies have you had? _____

27. How many children have you had? _____

28. How many miscarriages have you had? _____

29. If you are no longer having menstrual (monthly) periods, at what age did you stop having periods? _____

MALE AND FEMALE

	Yes	No
30. Have you often had:		
Pain in your back that was so bad you were not able to do your usual work?	☐	☐
Painful joints or swollen joints involving hands or feet?	☐	☐
31. Have you recently had:		
Large glands (lumps, swelling) in your neck?	☐	☐
Large glands in your arm pits?	☐	☐
Large glands in your groin?	☐	☐
Any change in a mole?	☐	☐
32. Do you have a tendency to bleed and/or bruise easily?	☐	☐
33. Did you ever smoke?	☐	☐
If **YES**, have you smoked:		
10 years or more?	☐	☐
One or more packs a day?	☐	☐

	Yes	No
Are you currently smoking?	☐	☐
34. Do you drink alcoholic beverages?	☐	☐
If YES, do you drink:		
2 or more glasses of wine a day?	☐	☐
2 or more glasses of beer a day?	☐	☐
2 or more cocktails a day?	☐	☐
35. At any time in the past were you a heavy alcoholic drinker?	☐	☐
36. Does your husband/wife think you drink too much?	☐	☐
37. Do you have any sexual problems you wish to discuss?	☐	☐

38. What has been your main occupation (kind of work) for most of your life? _____

In what business or industry? _____

39. Please list all types of exercise you do, including frequency (days per week) and duration (minutes per session)

EXERCISE	FREQUENCY	DURATION

Reviewed by physician: _____ *Date:* _____