Name:
DOB:
Chart:
Age:
Date:

Family Health History:

Please list any problems that run in your family to include bad reactions to anesthesia, easily bruised or bleeding, diabetes, cancer, heart attack before age of 55, arthritis, etc.

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Child	☐ M ☐ F	
Mother			Child	☐ M ☐ F	
Sibling	☐ M ☐ F		Child	☐ M ☐ F	
Sibling	☐ M ☐ F		Grandparents	☐ M ☐ F	

Bone Health: *Check any of the below that you have had.*

- ☐ Fracture from a fall or low impact injury
- ☐ Fracture of the wrist, spine or hip
- ☐ Vitamin D Deficiency
- ☐ Frequent Falls
- ☐ Long term use of steroids (Name of steroid and what you took it for) ____________
- ☐ Had a Bone Mineral Density Test (DXA Scan). If yes, when and where? ____________
- ☐ Had treatment for Osteoporosis. If yes, what and when? ____________

Social History:

☐ Work in the home ☐ Employed (occupation ____________) ☐ Student ☐ Daycare ☐ Retired
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Children? ☐ No ☐ Yes, # ______
Do you live alone? ☐ No ☐ Yes
Exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
What type of exercise? ____________
History of substance abuse? ☐ No ☐ Yes What? ____________
Smoke currently? ☐ No ☐ Yes Packs per day ______ for ______ years
Quit smoking? ☐ This year ☐ Less than a year ☐ Less than five years ☐ Less than 10 years
Previously smoked ______ packs per day for ______ years
Drink alcohol? ☐ Daily ☐ 1-2 times a week ☐ 1-2 times per month ☐ 1-2 times per year

Review of Systems:

Mark yes or no and CHECK any of the following you have recently had:

Constitutional Symptoms ☐ No ☐ Yes
☐ Fatigue ☐ Fever ☐ General aching ☐ Night sweats
☐ Unintentional weight gain ☐ Unintentional weight loss

Eye Problems ☐ No ☐ Yes
☐ Blurred vision ☐ Red eye ☐ Sensitivity to light

Cardiovascular Problems ☐ No ☐ Yes
☐ Blacking out or fainting ☐ Chest pain
☐ Irregular heart beat

Respiratory Problems ☐ No ☐ Yes
☐ Frequent productive cough ☐ Shortness of breath
☐ Wheezing

Abdominal Pain ☐ No ☐ Yes
☐ Change in bowel habits ☐ Nausea ☐ Vomiting

Neurologic Problems ☐ No ☐ Yes
☐ Difficulty walking ☐ Numbness ☐ Tingling

Psychiatric Problems ☐ No ☐ Yes
☐ Feels nervous (anxiety) ☐ Feels sad (depression)
☐ Trouble sleeping

Endocrine Problems ☐ No ☐ Yes
☐ Feels cold

Hematologic/Lymphatic Problems ☐ No ☐ Yes
☐ Bruises easily

Allergic, Infectious, Immunologic ☐ No ☐ Yes
☐ Infections recurring

Patient Signature: ______________________ Date: ______

TO ALL FEMALE PATIENTS: For your safety, if you are pregnant or think you may be pregnant, inform the doctor prior to your x-ray examination.