

**Physician to fill!**

**Pt name** \_\_\_\_\_

**J#** \_\_\_\_\_

**MEDICAL FORM:**

39. What was your height at age 20 years?

\_\_\_\_\_ cm. **or** \_\_\_\_\_ inches **or** \_\_\_\_\_ Don't know

40. Have you noticed any loss of height in adulthood?

\_\_\_ 1. No

\_\_\_ 2. Yes

l  
If yes, how much? \_\_\_\_\_ cm. **or** \_\_\_\_\_ inches

41. Atraumatic fracture(s) experienced? (Definition: a fracture caused by a fall from

\_\_\_ 1. No

\_\_\_ 2. Yes

standing height or by trauma that is insufficient to cause a fracture in otherwise healthy persons)

l  
If yes, site of fracture(s):

\_\_\_ hip

\_\_\_ wrist

\_\_\_ vertebrae

\_\_\_ rib

\_\_\_ ankle

\_\_\_ other (specify): \_\_\_\_\_

42. Do you have a family history of osteoporosis (Dowager's hump, height loss, fractures)?

\_\_\_ 1. No

\_\_\_ 2. Yes

\_\_\_ 3. Don't know

43. If yes, in whom:

\_\_\_ 1st degree relatives

\_\_\_ 2nd degree relatives

\_\_\_ other relatives (specify) \_\_\_\_\_

44. Have you ever been prescribed Prednisone (cortisone/steroids) by mouth for a period of at least 6 months?

\_\_\_ 1. No

\_\_\_ 2. Yes

l  
If yes, for how long? \_\_\_\_\_ months

If you have taken Prednisone for > 6 months, please indicate:

the maximum dose: \_\_\_\_\_ mg

the average dose: \_\_\_\_\_ mg

**FEMALES ONLY: MALES PLEASE PROCEED TO QUESTION #69**

45. How old were you when you started your periods?  
\_\_\_\_\_ years **or** \_\_\_\_\_ Don't know

46. Have your periods been regular?  
\_\_\_ 1. Yes, always regular  
\_\_\_ 2. No, sometimes irregular  
\_\_\_ 3. No, always irregular

47. Have your periods ever stopped for over 6 months and then restarted? (not applicable for menopausal status)

\_\_\_ 1. No  
\_\_\_ 2. Yes

If yes, how long were you without periods? \_\_\_\_\_ months (cumulative)

48. Have you ever been on an oral contraceptive pill?

\_\_\_ 1. No  
\_\_\_ 2. Yes

for how many years? \_\_\_\_\_ years

Did you have any side effects?

\_\_\_ 1. No  
\_\_\_ 2. Yes. Please specify: \_\_\_\_\_

49. Have you ever been pregnant?

\_\_\_ 1. No  
\_\_\_ 2. Yes

How many pregnancies have you had, including miscarriages or abortions?  
\_\_\_\_\_ **pregnancies**

50. Did you breastfeed any or all of your children?

\_\_\_ 1. No  
\_\_\_ 2. Yes

If yes, what is the combined, total length of time that you breastfed your children? \_\_\_\_\_ **months**

51. Have you had a hysterectomy (removal of womb/uterus)?

\_\_\_ 1. No  
\_\_\_ 2. Yes

If yes, at what age? \_\_\_\_\_ years

52. What was the reason for the hysterectomy?  
 endometriosis  
 fibroids  
 bleeding  
 ovarian cancer  
 uterine cancer  
 other (specify): \_\_\_\_\_

53. Have either of your ovaries been removed?  
 1. No, neither | (continue below)  
 2. Yes, unilateral | (continue below)  
 3. Yes, bilateral

If you did not have both ovaries removed, was menopause diagnosed at a later date?

1. No  
 2. Yes  
 3. Don't know

| If yes, at what age? \_\_\_\_\_ years

54. Have your periods stopped for longer than 1 year?  
 1. No  
 2. Yes

| If yes, at what age? \_\_\_\_\_ years

**OR**  at time of hysterectomy

55. If you are not having periods any longer, are you currently suffering from hot flashes, flushes, night sweats, insomnia, or periods of depression?  
 1. No  
 2. Yes

56. When was your last PAP test or pelvic/internal examination?  
\_\_\_\_/\_\_\_\_ **or** \_\_\_\_\_ I don't recall **or** \_\_\_\_\_ never had one  
mm / yyyy

57. Were there any abnormalities?  
 1. No  
 2. Yes  
 3. Don't know

58. Have you ever had a mammogram?  
 1. No  
 2. Yes  
 3. Don't Know  
| If yes when was your most recent mammogram? \_\_\_\_/\_\_\_\_

59. Were any abnormalities noted?  
 1. No  
 2. Yes (specify) \_\_\_\_\_  
 3. Don't know

60. Have you ever been told that you have fibrocystic breast disease?

- 1. No
- 2. Yes
- 3. Don't know

61. Have you ever had breast cancer?

- 1. No
- 2. Yes

If yes, in what year \_\_\_\_\_

Did you receive any of the following treatments?

- 1. Radiation/Chemotherapy
- 2. Tamoxifen
- 3. Other, specify \_\_\_\_\_

62. Do you have a family history of breast cancer?

- 1. No
- 2. Yes
- 3. Don't know

63. If yes, in whom:

- 1st degree relatives
- 2nd degree relatives
- other relatives (specify) \_\_\_\_\_

64. Do you have a family history of any of the following?

- ovarian cancer (in whom?) \_\_\_\_\_
- heart disease (in whom?) \_\_\_\_\_
- colon cancer (in whom?) \_\_\_\_\_
- Alzheimer's disease (in whom?) \_\_\_\_\_

Additional notes :

(cont'd.....)

65. Have you ever been prescribed estrogen replacement therapy?

- 1. No
- 2. Yes

66. If estrogen has been used, what is the **PAST** experience (specify brand and dose)?

ESTROGEN	DURATION
1. <input type="checkbox"/> Oral _____	_____ years
2. <input type="checkbox"/> Patch _____	_____ years
3. <input type="checkbox"/> Climacteron Injections	_____ years
4. <input type="checkbox"/> Vaginal cream	_____ years

PROGESTERONE	DURATION
1. <input type="checkbox"/> Oral _____	_____ years
<input type="checkbox"/> cyclical	
<input type="checkbox"/> continuous	
2. <input type="checkbox"/> Topical cream	_____ years

P  
a  
s  
t

67. If you are **CURRENTLY** on estrogen replacement therapy, please specify dose and duration:

ESTROGEN	DURATION
1. <input type="checkbox"/> Oral _____	_____ years
2. <input type="checkbox"/> Patch _____	_____ years
3. <input type="checkbox"/> Climacteron Injections	_____ years
4. <input type="checkbox"/> Vaginal cream	_____ years

PROGESTERONE	DURATION
1. <input type="checkbox"/> Oral _____	_____ years
<input type="checkbox"/> cyclical	
<input type="checkbox"/> continuous	
2. <input type="checkbox"/> Topical cream	_____ years

C  
u  
r  
r  
e  
n  
t

68. Menopausal Status

- 1. Pre
- 2. Peri
- 3. Post. \_\_\_\_\_
- 4. Unsure \_\_\_\_\_

## MALES ONLY:

69. Do you have any biological children?

- 1. No
- 2. Yes

70. If no, have you been diagnosed with a fertility problem?

- 1. No
- 2. Yes
- 3. Don't know

71. Which of the following is your usual experience regarding partial erections upon awakening in the morning?

- 1. Every day
- 2. Most days
- 3. Some days
- 4. Occasionally
- 5. Rarely
- 6. Never

72. Have you ever been treated with male hormones (testosterone)?

- 1. No
- 2. Yes

73. Have you been diagnosed with prostate enlargement?

- 1. No
- 2. Yes

74. Have you been diagnosed with prostate cancer?

- 1. No
- 2. Yes

If yes, in what year \_\_\_\_\_

Did you receive any of the following treatments?

- 1. Surgery
- 2. Medications (specify): \_\_\_\_\_
- 3. Other (specify): \_\_\_\_\_

(cont'd.....)

**Physical exam**

BP /

General Exam:

Costal Margin to Pelvic rim \_\_\_\_ fingerbreadths

Kyphosis? Y N other deformitiy?

**75. Current Prescribed Treatment (brand and dose)**

- 1. estrogen\_\_\_\_\_
- 2. progesterone\_\_\_\_\_
- 3. calcium\_\_\_\_\_
- 4. Vitamin D\_\_\_\_\_
- 5. raloxifene (Evista)\_\_\_\_\_
- 6. cyclical etidronate (Didrocal)\_\_\_\_\_
- 6. alendronate (Fosamax)\_\_\_\_\_
- 7. risedronate (Actonel) \_\_\_\_\_
- 8. testosterone\_\_\_\_\_
- 9. calcitonin(Miacalcin)\_\_\_\_\_
- 10. other (specify)\_\_\_\_\_

76. Spine x-ray Date: \_\_\_/\_\_\_/\_\_\_\_\_ **OR** \_\_\_pending

Any fractures? \_\_\_1. No  
\_\_\_2. Yes

**77. PLAN/Notes:**

---



---



---



---



---