

SUSSEX COUNTY MEDICAL ASSOCIATES  
123 NEWTON-SPARTA ROAD  
NEWTON, NJ 07860

## Patient History

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Please answer the following questions. If you are not sure how to answer a question, leave the space blank and we will assist you with the answer when you are seen at our facility. All answers will be kept in strict confidence and treated as medical record information.

1. Name \_\_\_\_\_
2. Street Address \_\_\_\_\_
3. City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
4. Height \_\_\_\_\_
5. Weight \_\_\_\_\_
6. Race  
African American\_\_\_\_ Asian\_\_\_\_ Caucasian\_\_\_\_ Hispanic\_\_\_\_ Native American\_\_\_\_ Other\_\_\_\_\_
7. Sex  
Female \_\_\_\_\_ Male \_\_\_\_\_
8. Referring Physician (if any) \_\_\_\_\_

- |                                                                                                                                                                  | <u>YES</u> | <u>NO</u> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|
| 9. Have you fractured any bones during your adult life?                                                                                                          | ___        | ___       |
| 10. Does your family have a history of osteoporosis?                                                                                                             | ___        | ___       |
| 11. Do you smoke more than half a pack of cigarettes per day?                                                                                                    | ___        | ___       |
| 12. Have you smoked in the past?                                                                                                                                 | ___        | ___       |
| 13. Do you have 3 or more serv. of dairy products every day?<br>(One serving = 8oz. milk, 1.5oz. cheese, 8oz. yogurt,<br>8oz. cottage cheese, or 4oz. ice cream) | ___        | ___       |
| 14. Have you consumed three or more dairy servings per day<br>throughout most of your life?                                                                      | ___        | ___       |
| 15. Do you take a calcium supplement daily?<br>If so, how much?<br>0-500mg/day _____ 501-1000mg/day _____ More than 1000mg/day _____                             | ___        | ___       |
| 16. Do you exercise at least three times per week?                                                                                                               | ___        | ___       |
| 17. Do you drink more than two alcoholic beverages per day?                                                                                                      | ___        | ___       |
| 18. Have you taken any of the following meds. or treatments?                                                                                                     |            |           |
| a. Steroids (Prednisone, cortisone, etc.)                                                                                                                        | ___        | ___       |
| b. Thyroid medication                                                                                                                                            | ___        | ___       |
| c. Anticonvulsants (for seizures, epilepsy)                                                                                                                      | ___        | ___       |
| d. Loop diuretics (Lasix, Bumex, Edicrin)                                                                                                                        | ___        | ___       |
| e. Heparin                                                                                                                                                       | ___        | ___       |
| f. Chemotherapy                                                                                                                                                  | ___        | ___       |
| g. Lithium                                                                                                                                                       | ___        | ___       |

- |                                                                      | <u>YES</u> | <u>NO</u> |
|----------------------------------------------------------------------|------------|-----------|
| 19. Have you had any of the following conditions?                    |            |           |
| a. Hyperthyroidism or Hyperparathyroidism                            | ___        | ___       |
| b. Biliary cirrhosis                                                 | ___        | ___       |
| c. Kidney disease                                                    | ___        | ___       |
| d. Rheumatoid arthritis                                              | ___        | ___       |
| e. Other arthritis                                                   | ___        | ___       |
| f. Part of stomach removed                                           | ___        | ___       |
| g. Intestinal or bowel disease                                       | ___        | ___       |
| h. Eating disorders (anorexia nervosa, bulimia, etc.)                | ___        | ___       |
| 20. Do you have any general comments or questions about your health? |            |           |
|                                                                      |            |           |
|                                                                      |            |           |

***Remaining Questions for Women Only***

- |                                                                             |     |     |
|-----------------------------------------------------------------------------|-----|-----|
| 21. Have you gone through menopause?                                        | ___ | ___ |
| 22. Did your menopause occur before age 45?                                 | ___ | ___ |
| 23. Have you ever had amenorrhea (missed periods or never started periods)? | ___ | ___ |
| 24. Have you ever taken hormones (not including birth control pills)?       | ___ | ___ |
| 25. Have you ever had any of the following side-effects from hormones?      |     |     |
| a. Breast tenderness                                                        | ___ | ___ |
| b. Heavy periods or intermittent bleeding/spotting                          | ___ | ___ |
| c. Headaches                                                                | ___ | ___ |
| d. Weight gain or fluid build-up                                            | ___ | ___ |
| e. Other _____                                                              | ___ | ___ |
| 26. Have you ever been treated for osteoporosis or weak bones?              | ___ | ___ |
| If so, what was the treatment? _____                                        |     |     |
| 27. Have you had any of the following conditions?                           |     |     |
| a. Hysterectomy                                                             | ___ | ___ |
| b. Ovaries removed                                                          | ___ | ___ |
| c. Blood clots                                                              | ___ | ___ |
| If yes, were you on hormones at the time?                                   | ___ | ___ |
| d. Breast cancer                                                            | ___ | ___ |
| e. Family history of breast cancer                                          | ___ | ___ |
| f. Cancer of the uterus (womb)                                              | ___ | ___ |

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**For Office Use Only**

Height \_\_\_\_\_ inches      Weight \_\_\_\_\_ lbs.      MRN \_\_\_\_\_

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