ATHENS PHYSICAL THERAPY
ATHENS NEURO AND BALANCE REHABILITATION
PHYSICIANS BACK AND NECK CLINIC
BETTER BONE CLINIC
CHRISTOPHER E. DOERR, D.O., P.C.

BETTER BONE CLINIC HISTORY

Patient Name____ Date of Birth________________

Your tallest height (late teens or young adult): ______________ Your current height: _________________

Have you broken any bones after age 40? YES/NO

BONE	DATE	AGE	HOW DID IT HAPPEN?

Has a parent or sibling had a fragility fracture (a fracture resulting from a fall from a standing height)? YES/NO

BONE DENSITY TEST (DXA SCAN) HISTORY

DATE	Physician who ordered	Facility where it was completed

Have you ever taken any of the following medications?

	EXAMPLES	YES	NO
Medication for seizures/epilepsy	Dilantin, Depakote, Neurontin, Tegretol, Lamictal		
Chemotherapy for cancer	Methotrexate, Arimidex, etc.		
Oral or injected steroids/cortisone for asthma/arthritis/inflammatory disorders	Medrol, Prednisone		
Thyroid medication	Synthroid (levothyroxine), PTU, Tapazole		
Hormone suppression for cancer or endometriosis	Lupron, Tamoxifen, Arimidex		
Gastric Reflux medication	Prilosec, Nexium, Dexilant, Protonix, Prevacid		
Narcotic pain medication	Hydrocodone, Oxycontin, Codeine		
Lithium	Eskolith, Lithobid		
Blood thinners	Heparin, Coumadin (Warfarin)		
Hormone Replacement	Estrogen, Testosterone		
Osteoporosis medication	Fosamax, Actonel, Boniva, Reclast, Prolia, Evista, Forteo		
Calcium supplements	Tums, Caltrate, OsCal		
Vitamin D	Calciferol, Cholecalciferol, DDrops		

Have you had cancer? YES (type and year of diagnosis _____________________________) NO
How was it treated? ☐ Surgery ☐ Radiation ☐ Chemotherapy
If breast cancer: Tamoxifen (from ________ to ________)
Aromatase Inhibitor (from ________ to ________)

Have you been diagnosed with Paget's disease?	YES	NO
Have you had hyperparathyroidism or a high calcium level in your blood?	YES	NO
Have you ever had gastric bypass surgery? (date__________)	YES	NO
Do you have celiac disease or other malabsorption syndrome?	YES	NO
Do you have any kind of kidney disease?	YES	NO
Is there a family history of osteoporosis?	YES	NO
Have you fallen in the last year?	YES	NO

If so, how many times? _____

FOR WOMEN:

Age when you began having menstrual periods ______

Age when you stopped having periods (menopause) ______

- ☐ Natural menopause?
- ☐ Surgical menopause?
  - ☐ Hysterectomy but kept ovaries
  - ☐ Hysterectomy plus ovaries removed

Hormone replacement therapy? YES/NO

If yes, when did it begin?

- ☐ Shortly after menopause (months)?
- ☐ Later after menopause (____ years after menopause)

Are you still on hormone replacement therapy? YES/NO

If no, when did you stop? ________________

How long were you on it? ________ year(s)

My signature below confirms that the information provided on this document is accurate to the best of my knowledge.

Patient Signature: ____ Date: ___________________

Parent/Guardian's Signature: ____ Date: ___________________