Englewood Orthopedic Associates
401 South Van Brunt Street • Englewood, NJ 07631
Tel: 201.569.2770 • Fax: 201.569.1774

Jessica Fleischer, MD

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Age: _____ DOB: ____/____/____ Gender: M☐ F☐ Race/Ethnicity _____

Home Phone: _____ Cell Phone: _____

Is it OK to leave voicemail messages on these phones? Yes☐ No☐

Referring Physician: _____ Phone: _____ - _____

Address: _____

Primary Care: _____ Phone: _____ - _____

Address: _____

Ob/Gyn: _____ Phone _____ - _____

Address: _____

Please list any other treating physicians:

- _____
- _____

Please let us know which particular concerns or questions you would like to discuss at your visit:

_____

_____

_____

_____

OSTEOPOROSIS HEALTH HISTORY

Have you ever had a Bone Density test? Yes ☐ No☐
Is so, when & where was the most recent one?
Date: **Location:**

Have you ever had a Bone Fracture? Yes☐ No☐
If yes, list the year/age, which bone and the circumstances of the fracture.

Year	Age	Bone Fracture	Circumstances

Osteoporosis Risk Factors: *Please indicate **YES or NO** if you have/had any of the following:

	Yes	No		Yes	No
Weight less than 127 lbs			Diabetes		
Height Loss			Cushing's Syndrome		
Bone Fractures			Thyroid Disease		
Scoliosis			Parathyroid Disease		
Parent with hip fracture			Kidney Disease		
Anorexia or Eating Disorder			Kidney Stones		
Menopause before age 45			Liver Disease		
Menopause after age 45			Celiac Disease		
Testosterone Deficiency			Ulcerative Colitis or Crohn's		
Avoidance of Dairy Products			Gastrectomy (stomach surgery)		
Lactose Intolerance			Bariatric/Weight Loss surgery		
Low Dairy intake in childhood			Lung Disease		
Vitamin D deficiency			Emphysema or Asthma		
Avoidance of Sunshine			Rheumatoid Arthritis		
Always use sunscreen			SLE (Lupus)		
Sedentary lifestyle			Ehlers Danlos		
Lack of exercise			Breast Cancer		
Current Tobacco			Prostate Cancer		
Past Tobacco			Multiple Myeloma		
Excess Alcohol use			Other Cancer		
Poor Balance/Tendency to Fall			Organ Transplantation		

Please check if you have taken any of the following medications:

	Yes	No		Yes	No
Glucocorticoids/Steroids/Prednisone			Diuretics		
Seizure Medications			Thyroxine (Synthroid)		
SSRI Anti Depressants			GnRH Agonists or Aromatase Inhibitors		
Sedatives or Sleeping Pills			Coumadin/Heparin		

FEMALE, MALE AND DENTAL HISTORY

FEMALE HISTORY (WOMEN ONLY)

Age when menstrual periods began: _____
Age when menses ended: _____
If still menstruating, date of last menstrual period: _____
Menses were/are: Regular □ Irregular□
Have you had a Hysterectomy? Yes□ No□ If Yes, what age? _____
If yes, were both ovaries removed? Yes□ No□
Did you ever miss your periods for more than six months, other than pregnancy or near menopause?
Yes □ No □

Number of pregnancies: _____ Number of live births: _____
Did you breast feed? _____ For how long? _____
Oral contraceptive use: _____ For how long? _____
Hormone therapy use: _____ For how long? _____
Date of last Pap smear: _____ Date of last mammogram: _____

MALE HISTORY (MEN ONLY)

Approximate age of puberty: _____ Age you started shaving: _____

Change in shaving pattern: Yes □ No □

Decreased sexual desire: Yes □ No □

Difficulty with erections: Yes □ No □

DENTAL HEALTH

Dental visits per year: _____ Last dental visit: _____
Dental Implants: Yes □ No □
Past Procedures: _____
Do you have any Future **DENTAL** procedures Planned: Yes □ No □
If, so please please indicate the planned procedure: _____

MEDICATION HISTORY

Please list your current intake of Calcium & Vitamin D:

	Brand	mg of calcium per pill	IU Vitamin D per pill	# of pills per day	Total
Calcium					
Vitamin D					
Multi Vitamin					

GRAND TOTAL DAILY CALCIUM: _____mg

GRAND TOTAL DAILY VITAMIN D: _____IU

MEDICATIONS: Please list all of your current medications and dosages, be sure to include prescription medications, other vitamins, supplements or over the counter medications.

Medication and Dosage	Medication and Dosage
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

Please list the use (current or past) of any of the following medications:

Medication	Yes	No	Date Started	Date Stopped	Reason Stopped
Fosamax (Alendronate)					
Actonel (Risedronate)					
Boniva (Ibandronate)					
Reclast (Zoledronate)					
Forteo (Teriparatide)					
Miacalcin Nasal Spray					
Premarin/Prempro					
Other Estrogens or Hormones					
Evista (Raloxifene)					
Prolia (Denosumab)					

MEDICAL HISTORY

Medical History:

Diagnosis	Date Diagnosed

Surgical/Procedure History:

Surgery/Procedure	Date

Family History:

	Alive/Deceased	Age	Osteoporosis	Hip Fracture	Disease	Cause of Death
Father			Yes No	Yes No		
Mother			Yes No	Yes No		
Siblings			Yes No	Yes No		
			Yes No	Yes No		
			Yes No	Yes No		
Children			Yes No	Yes No		
			Yes No	Yes No		
			Yes No	Yes No		

SOCIAL HISTORY/HABITS

Birthplace: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Do you live alone: Yes ☐ No ☐ Your Occupation: _____

Smoking currently: Yes ☐ No ☐ _____ packs for _____ years.

Previously smoked: _____ packs for _____ years. Quit (year/age) _____

Do you consume alcoholic beverages: Yes ☐ No ☐

Quantity (Number of alcoholic beverages): _____ Daily Weekly Monthly

How many cups of caffeinated beverages do you consume daily: 0 1 2 3 or more

Do you exercise regularly: Yes ☐ No ☐ Describe: _____

Daily servings of Dairy: 0 1 2 3 or more

Daily servings of Green-Leafy Vegetables: 0 1 2 3 or more

ALLERGIES

Please list any food or medication allergies below: **No Allergies:**

_____

Review of Systems: Please check off any problems with the following:

	Yes	No		Yes	No
Fatigue			Hot Flashes		
Night Sweats			Vaginal Dryness		
Weakness			Decreased Libido		
Weight Loss			Milky Breast Discharge		
Weight Gain			Back Pain		
Eyes			Joint Pain		
Tunnel Vision			Bone Pain		
Ears, Nose & Throat			Double Jointed/Joint Laxity		
Hoarseness			Poor Balance		
Tooth Loss			Tremor		
Heart			Depression		
Lungs/Breathing			Anxiety		
Constipation			Insomnia		
Diarrhea			Excessive Urination		
Heartburn/Reflux			Excessive Thirst		

Please check if you have or have had any of the following: (Describe Yes responses)

	Yes	No	
Hot Flashes			If yes,
Blood Clots			If yes,
Radiation Treatment			If yes,
Reflux or heart Burn			If yes,
Barrett's Esophagus			If yes,
Recurrent Infections			If yes,

Height and Weight

What is your current height: _____ What is your current weight: _____
What was your maximum height: _____ What was your lowest adult weight: _____
At what age: _____

CLINICAL USE ONLY

Ht:_____ **BP:_____**

Wt:_____ **Pulse:_____**

General _____
HEENT: _____
Dentition: _____
Neck: _____
Lungs: _____
CV: _____
Abd: _____
Ext: _____
Spine: _____
Gait: _____
Balance: _____
Other: _____

Imp:

Plan:

I have reviewed the Questionnaire in detail with the patient including: PMH, PSH, FH, SH, Meds, Allergies and ROS.

Jessica Fleischer, MD _____ Date _____