Patient Name:
DOB:
MR #:

IOWA BONE CARE CENTER
New Patient Intake Form

Welcome to our clinic! Please bring this completed form along with a list of your current medications and supplements (or bring all your medication bottles) to your appointment.

Iowa Bone Care Center
Beat the Break

Have you broken any bones after age 40? ☐ Yes ☐ No

Bone	Date	How did it happen (e.g. car accident, fall, etc.)?

Have you ever had a DXA scan? ☐ Yes ☐ No
If yes, where did you have it performed: _____ When? (month/yr) _____

Have you taken any of these medications (now or in the past)?

Medication	Yes	No	When to when?	Why stopped?
Alendronate/Fosamax				
Risedronate/Actonel				
Ibandronate/Boniva				
Zoledronate/Reclast				
Denosumab/Prolia				
Teriparatide/Forteo				
Raloxifene/Evista				

Personal Medical History:

Condition	Yes	No
Parathyroid disease		
Thyroid disease		
Celiac disease		
Organ transplant		
Type: Date:		

Condition	Yes	No
Seizure		
Cancer(type_____)		
Year of diagnosis: ☐ Surgery ☐ Radiation ☐ Chemotherapy If breast cancer: ☐ Tamoxifen_____ to _____ ☐ Aromatase Inhibitor _____ to _____		

Does osteoporosis run in your family? ☐ Mother ☐ Father ☐ Other

Has either of your parents broken a hip? ☐ Mother ☐ Father

What was your tallest height?_____ What is your current height? _____

Have you gained or lost >10 lbs. in the past year? ☐ Yes ☐ No

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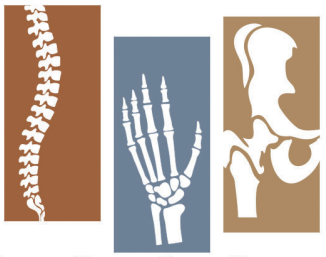

Do you have chronic diarrhea? ☐ Yes ☐ No

Have you ever had a kidney stone? ☐ Yes ☐ No

Do you have wheezing or shortness of breath? ☐ Yes ☐ No

Do you have problems with balance? ☐ Yes ☐ No

Do you have problems with vision? ☐ Yes ☐ No

Have you had an irregular heart rhythm? ☐ Yes ☐ No

Do you have any dental procedures needed/planned? ☐ Yes ☐ No

Do you have heartburn/reflux symptoms? ☐ Yes ☐ No

For Women:

☐ I still have periods.

They are ☐ regular ☐ irregular

☐ I have gone through menopause.
Age or date of last menstrual period:_____

☐ I have used hormone replacement/estrogen therapy.
Date:_____ to _____

For Men:

Do you have ED or low sex drive? ☐ Yes ☐ No

	Yes	No	Comments
Do you exercise regularly?			____minutes per day ____days per week
Do (or did) you smoke?			____packs per day for ____years. Quit date ____
Do you drink alcohol?			____drinks per day/week
Have you fallen in the past year?			If yes, how many times? ____
Have you ever taken prednisone or another steroid medication?			Date(s)/Duration:

Calcium Intake Calculator: Please fill in the table with the intake you have ***most every day.***

Dietary Calcium Sources	mg of calcium per serving	Servings per day	For clinic use
General diet	200-300		
1 cup milk	300		
6 oz. yogurt	300		
1.5 oz. cheese*	300		
3/4 cup TOTAL brand cereal	1000		
1 cup calcium- added OJ			

*For example, cheddar, mozzarella. ***Do NOT count cottage cheese or cream cheese.***

Supplemental Calcium Sources	mg of calcium per tablet	Servings per day	For clinic use
Multivitamin			
Calcium carbonate			
Calcium citrate			
Vitamin D (plain)	N/A		