



**Surgeries:**

Procedure	Hospital	Date

**Family Health History:**

Please list any problems that run in your family to include bad reactions to anesthesia, easily bruised or bleeding, diabetes, cancer, heart attack before age of 55, arthritis, etc.

	Age	Gender	Significant Health Problems		Age	Gender	Significant Health Problems
Father				Child		<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				Child		<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling		<input type="checkbox"/> M <input type="checkbox"/> F		Child		<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling		<input type="checkbox"/> M <input type="checkbox"/> F		Grandparents		<input type="checkbox"/> M <input type="checkbox"/> F	

**Bone Health:** Check any of the below that you have had.

- Fracture from a fall or low impact injury
- Fracture of the wrist, spine or hip
- Vitamin D Deficiency
- Frequent falls
- Long term use of steroids (Name of steroid and what you took it for)

\_\_\_\_\_

- Had a Bone Mineral Density Test (DXA Scan). If yes, when and where?

\_\_\_\_\_

- Had treatment for Osteoporosis. If yes, what and when?

\_\_\_\_\_

**Social History:**

<input type="checkbox"/> Work in the home?	<input type="checkbox"/> Employed (occupation _____)	<input type="checkbox"/> Student	<input type="checkbox"/> Daycare	<input type="checkbox"/> Retired	
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed	
Children?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	How many? _____		
Do you live alone?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Exercise?	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
What type of exercise? _____					
History of substance abuse?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	What? _____		
Have you ever been or are you currently on a pain contract?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	With Whom? _____		
Current Tobacco User?	<input type="checkbox"/> No	<b>Type:</b>	<input type="checkbox"/> Cigarettes: Packs/quantity per day _____	<input type="checkbox"/> E-Cig/Vape	<input type="checkbox"/> Smokeless Tobacco
Quit smoking?	<input type="checkbox"/> This year	<input type="checkbox"/> Less than a year	<input type="checkbox"/> Less than five years	<input type="checkbox"/> Less than 10 years	
Previously smoked _____ packs per day for _____ years.					
Drink alcohol?	<input type="checkbox"/> No	<input type="checkbox"/> Daily	<input type="checkbox"/> 1-2 times a week	<input type="checkbox"/> 1-2 times per month	<input type="checkbox"/> 1-2 times per year

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_