CAPITAL WOMEN'S CARE

Obstetrics & Gynecology

David H. Solberg, M.D., F.A.C.O.G.
Andrew J. Oh, M.D., F.A.C.O.G.
Mitesh B. Kothari, M.D., F.A.C.O.G.
Lisa N. Miller, M.D., F.A.C.O.G.
Laura Toso, M.D., F.A.C.O.G.
Jesse X. Woo, M.D., F.A.C.O.G.
Nadim N. Hawa, MD., F.A.C.O.G.
George E. Manger, M.D., F.A.C.O.G.

Lorraine A. Bowen, CNM, CRNP
Susan H. Funke, CNM
Andrea D. Groag, CNM
Erin Parish-Gibson, CNM
Lindsay K. McBurney, PA-C
Rebecca A. Kreps, PA-C
Hannah L. Crosby, PA-C
Brandy L. Baxter, MS, RD, LDN

1165 Imperial Drive, Suite 300
Hagerstown, MD 21740

Phone: (301) 665-9098
Fax: (301) 665-9096

Patient History Questionnaire

Patient Name: _____
Date of Birth: _____
Ethnicity: _____

1. Have you had a previous hip or vertebral fracture? ____Yes ____No
2. Have you had any fractures during your adult life which did not result from significant trauma? ____Yes ____No
3. Did either of your parents ever have a hip fracture? ____Yes ____No
4. Do you smoke? ____Yes ____No
5. Have you ever taken oral steroids, such as prednisone for greater than a 3 month time period? ____Yes ____No
6. Do you have rheumatoid arthritis? ____Yes ____No
7. Do you have a secondary osteoporosis? ____Yes ____No
8. Do you drink 3 or more alcoholic beverages a day? ____Yes ____No
9. Are you being treated for osteoporosis? ____Yes ____No

10. Have you ever taken any of the following medication(s):
    - ___ Actonel (i.e. risedronate)
    - ___ Boniva (i.e. ibandronate)
    - ___ Evista (i.e. raloxifene)
    - ___ Forteo (i.e. parathyroid hormone)
    - ___ Fosamax (i.e. alendronate)
    - ___ HRT (i.e. estrogen/hormone therapy)
    - ___ Miacalcin (i.e. calcitonin)
    - ___ Protelos (i.e. strontium ranelate)
    - ___ Reclast (i.e. zoledronate)
    - ___ Prolia (i.e. denosumab)
    - ___ Vitamin D
    - ___ Calcium
    - ___ Other, please specify _____
11. Do you have any of the following medical conditions:
    - ___ Anorexia or Bulimia
    - ___ Any Seizure Disorders
    - ___ Asthma or Emphysema
    - ___ Cancer
    - ___ End Stage Renal Disease
    - ___ Inflammatory Bowel Disease
    - ___ Hyperparathyroidism
    - ___ Hysterectomy
    - ___ Other, please specify _____
12. What was your maximum height (inches)? _____
13. Do you perform weight bearing exercises regularly? ____Yes ____No
14. Do you regularly consume dairy products? ____Yes ____No
15. Do you drink caffeinated beverages? ____Yes ____No
16. At what age did your period start? _____
17. Are you pre-menopausal? ____Yes ____No
18. How many full term pregnancies have you had? _____
19. Have you ever missed your period for more than 6 months in a row, not including pregnancy or menopause ____Yes ____No