Drs. Borders, Hood, & Associates

2101 Nicholasville Road, Suite 106; Lexington, KY 40503

John V. Borders, MD, FACP **Gregory A. Hood, MD, MACP**

Patient Name: ____________________ Exam Date: ______________

(Please print)

Patient Date of Birth (Month – Date – Year): ______________

Chrt #: **Ht. Baseline:** **Ht. Current:** **Wt.:** **BMI:** **Arm: R-** **L-**

WOMEN ONLY COMLETE THIS SECTION

Do you still menstruate?	Yes___	No___
If yes, is your menstruation	Regular___	Irregular___
If no, at what age did you stop? ______________		
Have you ever gone greater than 6 months without menses?	Yes___	No___
Have you had a hysterectomy	Yes___	No___
(Please circle one)	Partial	Complete
Do you or have you ever taken Estrogen?	Yes___	No___
Name and Dose__________________		
Currently on Estrogen	Yes___	No___

Do you have a history of, or currently have:

	Yes	No
Anorexia or Bulimia	___	___
Bed rest – prolonged or confinement	___	___
Cancer – Please identify type: ______________________	___	___
Celiac Disease/Sprue/Gluten Enteropathy	___	___
COPD/Asthma/Emphysema/Chronic Shortness of Breath	___	___
Crohn's Disease or Ulcerative Colitis	___	___
Depo Provera	___	___
Fracture, Non-traumatic (Non-injury)	___	___
Gastric Bypass or stomach surgery	___	___
Hyperparathyroidism	___	___
Hyperthyroidism/High Thyroid/Goiter	___	___
Hypothyroidism/Low Thyroid or Thyroid Surgery	___	___
Inflammatory Bowel Disease, Chronic Diarrhea	___	___
Kidney Disease	___	___
Male Hypogonadism/Low Testosterone	___	___
Phenytoin/Dilantin/Epilepsy or Seizure Medication	___	___

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Patient Name: ____________________ DOB: _____________ Exam Date: ________

Do you have:

	Yes	No
Lactose Intolerance, Milk Allergy, or Dairy Intolerance	___	___
Liver Disease or Cirrhosis	___	___
Lupus, Rheumatoid Arthritis, or other collagen diseases	___	___
Osteomalacia	___	___
Osteoporosis	___	___
Seizures/Epilepsy	___	___
Family history of Osteoporosis/Breaking Bones Easily	___	___
Family History of Breast Cancer	___	___

Do you currently or have a history of use/consumption of:

	Yes	No
Tobacco Type: _______ Amount: _______/day Duration: ________	___	___
Alcohol: Greater than 2 alcoholic beverages daily	___	___

Medications:-Are you taking now or have you ever taken:

	Yes	No
Actonel	___	___
Boniva	___	___
Evista	___	___
Forteo	___	___
Fosamax	___	___
Miacalcin	___	___
Prednisone, or other cortisone drug/steroids	___	___
Thyroid hormone	___	___

How much of the following medications are you taking?

Vitamin D Amount: __________________ How Often ________________

Calcium Amount: __________________ How Often ________________