EMORY
SPORTS MEDICINE
CENTER

BONE STRESS INJURY CLINIC

NEW PATIENT INTAKE QUESTIONNAIRE

Patient name: _____

Age: _____

Date of birth: _____

Today's date: _____

What sport(s) do you play or what exercise do you do? _____

Where is your pain? _____

Have you been diagnosed with an injury? YES ◯ NO ◯

If yes, what is the diagnosis? _____

BONE HISTORY:

Have you ever had a fracture or broken bone?

YES ◯ NO ◯

If yes, how many? _____

Which bone (s)? _____

When? _____

Have you ever had a stress fracture?

YES ○ NO ○

If yes, how many? _____

Which bone(s)? _____

When? _____

Are you currently being treated for a stress fracture:

YES ○ NO ○

When were you diagnosed? _____

Have you had xrays? YES ○ NO ○

Results: _____

Have you had an MRI? YES ○ NO ○

Results: _____

How have you been treated?

Time out of activity: YES ○ NO ○

If yes, how long have you been out? _____

Walking boot: YES ○ NO ○

If yes, how long have you been in the walking boot? _____

Bone stimulator: YES ○ NO ○

If yes, how long have you used the bone stimulator? _____

How long per day/how many times per day? _____

Have you ever had a DEXA scan to evaluate your bone density?

YES ○ NO ○

Results: _____

Have you had any labs done?

YES ○ NO ○

Results: _____

MENSTRUAL HISTORY

Age when you started your period? _____
Do you get regular periods every month? YES ◯ NO ◯
Have you had irregular periods in the past? YES ◯ NO ◯
Since starting your period, have you ever gone 6 months or longer without a period?
YES ◯ NO ◯

In the last 12 months, how many periods have your gotten? _____

Are you on birth control? YES ◯ NO ◯
If yes, what type? _____

NUTRITION HISTORY:

Current height _____
Current weight: _____
Highest weight: _____
Lowest weight at your current height: _____

Have you lost weight in the last 6 months? YES ◯ NO ◯

If yes, how much? _____

Have you lost weight in the last 12 months? YES ◯ NO ◯

If yes, how much? _____

Do you avoid certain food groups or follow a special diet? YES ◯ NO ◯

If yes, please describe: _____

Do you consume dairy? YES ◯ NO ◯

If yes, please describe: _____

Do you smoke? YES ◯ NO ◯

If yes, please describe: _____

Do you drink alcohol? YES ◯ NO ◯

If yes, please describe: _____

MEDICAL HISTORY:

Do you have osteoporosis? YES ◯ NO ◯
Do you have thyroid disease? YES ◯ NO ◯
Do you have celiac disease? YES ◯ NO ◯
Do you have an auto-immune disease? YES ◯ NO ◯
Do you have a history of anemia? YES ◯ NO ◯
Have you ever had a kidney stone? YES ◯ NO ◯
Please list other past or current medical diagnoses: _____
_____

MEDICATION HISTORY:

Are you currently taking any prescription medications regularly?
YES ◯ NO ◯

If yes, what medications (including frequency)? _____
_____

Are you currently taking any non-prescription medications or supplements regularly?
YES ◯ NO ◯

If yes, what medications/supplements (including frequency)? _____
_____

Have you ever taken oral steroids (prednisone?) YES ◯ NO ◯

If yes, how many times and for how long? _____

Have you ever taken medication for reflux? YES ◯ NO ◯

If yes, when and for how long? _____

Have you ever taken diuretics? YES ◯ NO ◯

If yes, please describe? _____

Do you take calcium (or have you in the past)? YES ◯ NO ◯

If yes, dose and frequency: _____

Do you take vitamin D (or have you in the past)? YES ◯ NO ◯

If yes, dose and frequency: _____

Do you take iron (or have you in the past)? YES ◯ NO ◯

If yes, dose and frequency: _____

FAMILY HISTORY:

Osteoporosis <60 yo in female relative	YES ◯	NO ◯
Osteoporosis in male relative	YES ◯	NO ◯
Thyroid disease	YES ◯	NO ◯
Autoimmune disease	YES ◯	NO ◯
Hip Fracture	YES ◯	NO ◯
Kidney stones	YES ◯	NO ◯

Other: _____

Please describe 'yes' answers from above: _____
_____

TRAINING REGIMEN:

Please detail a typical week in your sport/exercise including distance/duration, number of days per week, other: _____
_____
_____.

How many days per week do you rest (no training at all)? _____

How many days per week do you cross-train and what do you do for cross-training? _____
_____.

Do you wear orthotics? YES ◯ NO ◯

THANK YOU!
Please email your completed form to:
Womens.MSK.Admin@emoryhealthcare.org