



CHAPMAN UNIVERSITY

DEPARTMENT OF BIOLOGICAL SCIENCE

MEDICAL HISTORY FORM

<p>Please check if you taking or have taken any of the following?</p> <p>Fosamax _____</p> <p>Actonel _____</p> <p>Boniva _____</p> <p>Forteo _____</p> <p>Please list any other medications you are taking</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Name _____</p> <p>Age _____</p> <p>Ethnicity _____</p> <p>Last menstrual period _____</p> <p>Please list bone fracture history</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Do you have cancer, or have had a history of cancer? _____</p> <p>Diabetes? _____</p> <p>Rheumatoid arthritis? _____</p> <p>Thyroid problems? _____</p> <p>Eating disorders? _____</p> <p>How would you define your general health?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Are you taking or have you taken any of the following?</p> <p>Progesterone (no) _____ (yes) _____ (# of years) _____</p> <p>Prempro</p> <p>Premarin</p> <p>Estrogen</p> <p>Premarin</p> <p>Estrogen/Premarin combo</p> <p>Other, please describe</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Have you ever taken birth control pills?</p> <p>(no) _____ (yes) _____ (# of years) _____</p> <p>Do you take vitamins?</p> <p>(no) _____ (yes) _____</p> <p>How often do you take these vitamins?</p> <p>_____</p>