Osteoporosis Patient Questionnaire

Welcome to our clinic! Please bring this completed form to your appointment, along with a list of your current medications and supplements. **Please bring your calcium and vitamin D supplement bottles with you.**

NAME: Last _____ **First** _____

MI_____**Gender:** _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Partnered

Occupation: _____ **Retired - Previous Occupation:**_____

Is today's visit: ☐ **Follow-up appointment after hospital stay** ☐ **I was referred**

Who referred you: Please provide his or her name: _____

Medical History	Please check box for those conditions you have now or have ever had

☐ Depression
☐ Eating disorders (anorexia, bulimia)
☐ Celiac disease (gluten intolerance) or chronic diarrhea
☐ Colitis or inflammatory bowel disease (Crohn's, ulcerative colitis)
☐ Reflux or GERD
☐ Seizure disorder
☐ Vertigo or dizziness, lightheadedness
☐ Balance problems or peripheral neuropathy
☐ Parathyroid disease (hyperparathyroidism)
☐ High thyroid disease (hyperthyroidism)
☐ Diabetes
☐ Asthma or other lung problems
☐ Chronic kidney disease
☐ Kidney stones
☐ Rheumatoid arthritis or other types of autoimmune disease
☐ Prednisone or other steroid use daily for > 3 months
☐ Paget's disease ☐ soft tissue ☐ bone
☐ Sarcoid
☐ Cancer (type _____)
☐ Stroke
☐ Organ transplant

Have you lost any height? ☐ Yes ☐ No If so, how many inches? _____

Does osteoporosis run in your family? ☐ Mother ☐ Father ☐ Other

Did your parents ever break a hip? ☐ Yes ☐ No

Do you have any upcoming dental work, tooth extractions, or implants? ☐ Yes ☐ No

Have you had a bone density scan or DEXA? ☐ Yes ☐ No Date of most recent scan: _____
Where was it done? _____

Have you broken any bones after age 50?

☐ Yes ☐ No ☐ I am younger than 50

Date or year the fracture happened	What did you break? Example: hip, wrist, spine, etc.	Did your fracture come from a fall (standing or sitting height)?	Did your fracture come from some other type of accident? Please explain.

PLACE PATIENT LABEL HERE

FOR WOMEN

How old were you when your period started? _____

Periods:

- ☐ I still have regular periods
- ☐ I still have irregular periods
- ☐ I have gone through menopause (age or date of last menstrual period: _____)
- ☐ I have had a hysterectomy - Date: _____. My ovaries were ☐ Left in ☐ Taken out

Have you ever missed your period for more than 6 months in a row outside of pregnancy? ☐ Yes ☐ No

FOR MEN

Do you have erectile dysfunction or low sex drive? ☐ Yes ☐ No

Have you ever used testosterone? ☐ Yes ☐ No

PLEASE CHECK (√) IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING OVER THE LAST MONTH

- ☐ Muscle weakness
- ☐ Muscle cramps
- ☐ Unusual/new fatigue
- ☐ Weight loss
- ☐ Fever or Night sweats
- ☐ Swollen glands
- ☐ Loss of appetite
- ☐ Skin rash or hives
- ☐ Eczema or psoriasis
- ☐ Problems with your vision
- ☐ Problems with hearing
- ☐ Headache or migraine
- ☐ Shortness of breath
- ☐ Cough
- ☐ Heart pounding (palpitations)
- ☐ Trouble swallowing
- ☐ Heartburn or stomach gas
- ☐ Diarrhea
- ☐ Problems with urination

Medications	Yes	No	What year (or age) did you take this?	If you have stopped taking this, why?
Alendronate/Fosamax (weekly pill)				
Risedronate/Actonel (weekly or monthly pill)				
Ibandronate/Boniva (monthly pill or IV infusion every 3 months)				
Zoledronate/Reclast (once yearly IV infusion)				
Denosumab/Prolia (every 6 month shot)				
Teriparatide/Forteo (daily shot)				
Raloxifene/Evista (SERMS) (daily pill)				
Calcitonin (nasal spray)				
Hormone replacement therapy (daily pill)				
Estrogen Replacement therapy (daily pill)				
Testosterone				
Lupron				
Femara, Tamoxifen, aromatase inhibitors				

PLEASE TELL US ABOUT THE MEDICATIONS/SUPPLEMENTS YOU USE. (ATTACH A LIST IF EASIER)

CURRENT MEDICATIONS & SUPPLEMENTS	STRENGTH & NUMBER OF PILLS PER DAY

PLACE PATIENT LABEL HERE

PLEASE TELL US ABOUT YOUR HABITS:

	Yes	No	
Do you exercise regularly?			Minutes per day: _____ Days per week: _____
Have you fallen in the past year?			How many times? _____
How many cups of coffee/tea/soda do you drink?			Daily: _____ Weekly: _____
Do (or did) you drink alcohol?			Drinks per day: _____ Drinks per week: _____
Do you or have you ever smoked?			Packs per day: _____ Number of years: _____ Quit date: _____

PLEASE TELL US ABOUT YOUR CALCIUM AND VITAMIN D USE

Supplemental Calcium and Vitamin D Sources	Amount Calcium Per Tablet	Amount Vitamin D Per Tablet	Number of Tablets Per Day
Multivitamin			
Calcium Carbonate			
Calcium Citrate			
Calcium (other)			
Vitamin D			

Dietary Calcium	Servings Per Day	Dietary Calcium	Servings Per Day
1 cup milk		Luna Bars (or similar)	
1.5 oz. cheese		Fortified orange juice	
6 oz. yogurt		Soy/almond milk	
Green leafy vegetables		Tofu	
Sardines		Cereal (fortified)	

PLACE PATIENT LABEL HERE