Bone Health Follow Up

Provider Michelle Lalinde, FNP Today's Date_____

Patient Name_____

Start date of osteoporosis therapy _____ Any side effects? ◯ Yes ◯ No

If yes, please list _____

Do you take calcium supplements? ◯ Yes ◯ No

If yes, how long have you taken calcium supplements? _____

how much per day? _____

Does your calcium contain vitamin D? ◯ Yes ◯ No

If yes, how much? _____

How many servings of dairy products do you consume in a day(milk,yogurt,cheese,ice cream) _____

Do you drink alcohol? ◯ Yes ◯ No

If yes, how many drinks per week? _____

Do you exercise? ◯ Yes ◯ No

If yes, how many days a week? _____ for how long? _____

If yes, what kind of exercise? _____

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

Medication Name	**Dose**	**Frequency**
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		