Bone Health Questionnaire

Provider Michelle Lalinde, FNP **Today's Date**_____

Patient Name_____

Please answer the following:

Have you been diagnosed with Osteopenia or Osteoporosis? ___Yes _____No

Have you had a spine, hip, or wrist fracture after age 45? _____Yes _____No

Have you take Prednisone (5.0 mg/day or more) for 3 months or longer? ____Yes ___No

Do you have Hyperparathyroidism, or Cushing's Syndrome? _____Yes _____No

Have you had a previous Bone Mineral Density Test (DEXA)? _____Yes _____No
When did you have the last Bone Mineral Density Test (DEXA)? _____
Where did you have your last Bone Mineral Density Test (DEXA)?_____

What is your Peak Height (tallest height)? _____FT _____In

Is there a family history of bone fractures? _____Yes _____No
If so, who (mother, father, sibling(s) _____Where:_____

Is there a family history of osteoporosis? _____Yes _____No

How many days a week do you exercise and for how long? _____

Type of exercise (walking, yoga, pilates, swimming, biking, etc.):_____

History of eating disorder? _____Yes _____ No

How many alcoholic beverages do you drink per week? _____

Have you ever been a heavy drinker? _____Yes _____No How Long: _____

Do you smoke? _____Yes _____No
If no, did you previously smoke? ____Yes _____No If yes, when did you quit? ____
If yes, how many packs per day? _____
If yes, how long have you smoked? _____

Do you take calcium supplement? _____Yes _____No
If yes, How long have you taken calcium supplements? _____

How much per day? _____

How many glasses of milk do you drink per day? _____
per week? _____
Do you drink or eat any other calcium fortified products? _____Yes _____No
If yes, what type_____ How often_____

Does your calcium contain vitamin D? _____Yes _____No
If yes, how much? _____

Do you take a multivitamin? _____Yes _____No
If yes, does it contain vitamin D? ____Yes _____No How much_____
What type of vitamin D? _____

Women only:
Is there a chance you might be pregnant? _____Yes _____No

Approximate date of you last menstrual period: _____

Have you gone through menopause? _____Yes _____No
If yes, when? _____

Have you had a partial or full hysterectomy? _____Yes _____No
If yes, when? _____
Partial Hysterectomy _____ Full Hysterectomy_____

Have you ever stopped having menstrual periods for more than six months (other than when you were pregnant or at menopause)? _____Yes _____No

Are you currently taking estrogen therapy? _____Yes _____No
If yes, what brand name of estrogen: _____Dose: _____

Are you currently taking progesterone therapy? _____Yes _____No
If yes, what brand name of progesterone: _____Dose: _____

When did you start taking hormone therapy? _____
If yes, when did you start? _____
Brand name: _____ Dose: _____

Have you been taking hormone therapy continuously since menopause? _____Yes ___No
If no, when did you stop? _____

Have you ever had any of the following conditions or disease?

Yes	No	Conditions or Disease	Other Information	When were you diagnosed?
		Thyroid Disease	Underactive or Overactive	
		Seizure Disorder		
		Heart Disease		
		Asthma		
		Rheumatoid Arthritis		
		Celiac Disease		
		Paget's Disease		
		Arthritis of the Spine		
		Diabetes	Type I or Type II	
		Bowel Disease		
		Liver Disease		
		Cancer	What Type?	
		Kidney Disease		
		Other		

Are you currently taking or have you ever taken any of the following medication?

Yes	No	Medication	How Long?	Dose?
		Steroids (Prednisone)		
		Seizure Medications		
		Evista (Raloxifene)		
		Didronel (Etidronate)		
		Miacalcin (Calcitonin)		
		Fosamax (Alendronate)		
		Actonel (Risendronate)		
		Aredia (Pamidronate)		
		Forteo (Teriparatide)		
		Boniva (Idandronate)		
		Zometa (Zolendronic Acid)		
		Reclast (Zolendronic Acid)		
		Prolia (Denosumab)		

Please List Any Fractures or Breaks	Cause of the Fracture?	How old were you when you had the fracture?	Date of Fracture?

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)			
9)			
10)			