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)			