Patient History Questionnaire

Patient Name: _____ Date: _____

Patient ID: _____

Date of Birth: _____ Current Height: _____ Weight: _____

Referring Physician: _____ Menopause Age (if applicable): _____ Race: _____

1. Have you had a previous hip or vertebral fracture? ☐ Yes ☐ No

2. Have you had any fractures during your adult life which did not result from significant trauma (e.g., auto accident)? ☐ Yes ☐ No

3. Did either of your parents ever have a hip fracture? ☐ Yes ☐ No

4. Do you smoke? ☐ Yes ☐ No

5. Have you ever taken oral steroids? ☐ Yes ☐ No

6. Do you have rheumatoid arthritis? ☐ Yes ☐ No

7. Do you have secondary osteoporosis? ☐ Yes ☐ No

8. Do you drink 3 or more alcoholic drinks per day? ☐ Yes ☐ No

9. Are you being treated for osteoporosis? ☐ Yes ☐ No

10. Have you ever taken any of the following medications:

- ☐ Actonel (i.e. risedronate)
- ☐ Boniva (i.e. ibandronate)
- ☐ Evista (i.e. raloxifene)
- ☐ Forteo (i.e. parathyroid hormone)
- ☐ Fosamax (i.e. alendronate)
- ☐ HRT (i.e. estrogen/hormone therapy)
- ☐ Miacalcin (i.e. calcitonin)
- ☐ Protelos (i.e. strontium ranelate)
- ☐ Reclast (i.e. zoledronate)
- ☐ Prolia (i.e. denosumab)
- ☐ Vitamin D
- ☐ Calcium
- ☐ Other - Please specify: _____

11. Do you currently have any of the following medical conditions:

- ☐ Anorexia or Bulimia
- ☐ Any Seizure Disorders
- ☐ Asthma or Emphysema
- ☐ Cancer
- ☐ End stage renal disease
- ☐ Inflammatory bowel diseases
- ☐ Hyperparathyroidism
- ☐ Hysterectomy
- ☐ Other - Please specify: _____

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12. At any time in your life, what is the tallest you have measured (inches)? _____

13. While exercising, do you lift weights regularly? ☐ Yes ☐ No

14. Do you regularly consume dairy products? ☐ Yes ☐ No

15. Do you drink caffeinated beverages? ☐ Yes ☐ No

If Female:

16. At what age did your period start? _____

17. Are you premenopausal? ☐ Yes ☐ No

18. How many full term pregnancies have you had? _____

19. Have you ever missed your period for more than 6 months in a row (not including pregnancy or menopause)? ☐ Yes ☐ No