Patient Name:

DOB:

MR #:

Osteoporosis Clinic – New Patient Questionnaire

Welcome to our clinic! Please bring this completed form along with a list of your current medications and supplements (or bring all your medication bottles) to your appointment.

Have you broken any bones after age 40? ❒ Yes ❒ No

Bone	Date	How did it happen (e.g. car accident, fall, etc.)?

Have you taken any of these medications (now or in the past)?

Medication	Yes	No	When to when?	Why stopped?
Alendronate/Fosamax				
Risedronate/Actonel				
Ibandronate/Boniva				
Zoledronate/Reclast				
Denosumab/Prolia				
Teriparatide/Forteo				
Raloxifene/Evista				

Personal Medical History:

Condition	Yes	No
Parathyroid disease		
Thyroid disease		
Organ transplant		
Type: Date:		

Condition	Yes	No
Celiac disease		
Seizure		
Cancer (type __________)		
Year of diagnosis __________ ❒ Surgery ❒ Radiation ❒ Chemotherapy If breast cancer: ❒ Tamoxifen _____ to ______ ❒ Aromatase Inhibitor _____ to ______		

Does osteoporosis run in your family? ❒ Mother ❒ Father ❒ Other(s)_______________

Has either of your parents broken a hip? ❒ Mother ❒ Father

For Women:

❒ I still have periods. They are ❒ regular ❒ irregular

❒ I have gone through menopause. Age or date of last menstrual period: ___________

❒ I have used hormone replacement/estrogen therapy. Date: ________ to _________

Symptom Review:

What was your tallest height? ________ What is your current height? ___________

Have you gained or lost >10 lbs. in the past year? ❒ Yes ❒ No

Do you have chronic diarrhea? ❒ Yes ❒ No

Have you ever had a kidney stone? ❒ Yes ❒ No

Do you have wheezing or shortness of breath? ❒ Yes ❒ No

Do you have problems with balance? ❒ Yes ❒ No

Do you have problems with vision? ❒ Yes ❒ No

Have you had an irregular heart rhythm? ❒ Yes ❒ No

Do you have any dental procedures needed/planned? ❒ Yes ❒ No

Do you have heartburn/reflux symptoms? ❒ Yes ❒ No

For men: Do you have ED or low sex drive? ❒ Yes ❒ No

	Yes	No	Comments
Do you exercise regularly?			______ minutes per day ______ days per week.
Do (or did) you smoke?			___ packs per day for ___ years. Quit date _____
Do you drink alcohol?			______ drinks per day / week
Have you fallen in the past year?			If yes, how many times? ________
Have you ever taken prednisone or another steroid medication?			Date(s)/Duration:

Calcium Intake Calculator: *Please fill in the table with the intake you have most every day.*

Dietary Calcium Sources	mg of calcium/serving	Servings per day	For Clinic Use
General diet	200-300	1	
1 cup milk	300		
6 oz. yogurt	300		
1.5 oz. cheese*	300		
3/4 cup TOTAL brand cereal	1000		
1 cup calcium-added OJ	300		

*For example, cheddar, mozzarella. Do not count cottage cheese or cream cheese

Supplemental Calcium Sources	mg of calcium per tablet	IU of vitamin D per tablet	Number of tablets per day	For Clinic Use
Multivitamin				
Calcium carbonate				
Calcium citrate				
Vitamin D (plain)	N/A			