

PATIENT HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____

Patient ID: _____ Sex: M or F

Current Height: _____ Date of Birth: _____

Weight: (lb) _____ Referring Physician: _____

Menopause Age: _____ Ethnicity: _____

Please list any additional doctors to receive a copy of your report _____

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 Glucocorticoids? 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?

- | | | |
|--|---|--|
| <input type="checkbox"/> Actonel i.e. risedronate) | <input type="checkbox"/> Boniva (i.e. ibandronate) | <input type="checkbox"/> Evista (i.e. raloxifene) |
| <input type="checkbox"/> Forteo (i.e. parathyroid hormone) | <input type="checkbox"/> Fosamax (i.e. alendronate) | <input type="checkbox"/> HRT (i.e. estrogen/hormone therapy) |
| <input type="checkbox"/> Miacalcin (i.e. calcitonin) | <input type="checkbox"/> Protelos (i.e. strontium ranelate) | <input type="checkbox"/> Reclast (i.e. zoledronate) |
| <input type="checkbox"/> Prolia (i.e. denosumab) | <input type="checkbox"/> Vitamin D | <input type="checkbox"/> Calcium |
| <input type="checkbox"/> Other - Please Specify: _____ | | |

11. Do you have any of the following medical conditions?

- | | | |
|--|--|--|
| <input type="checkbox"/> Anorexia or Bulimia | <input type="checkbox"/> Any Seizure Disorders | <input type="checkbox"/> Asthma or Emphysema |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> End stage renal disease | <input type="checkbox"/> Inflammatory bowel disease |
| <input type="checkbox"/> Hyperparathyroidism | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Other - Please specify: _____ |

12. What was your maximum height (inches)? _____

13. Do you perform weight bearing exercise 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