TOWSON ORTHOPAEDIC ASSOCIATES

OFFICE USE ONLY
Patient Acct # _____
Doctor # _____

BONE HEALTH CENTER QUESTIONNAIRE

Name: _____ Date: _____

Who recommended us to you? _____

Family MD/NP/PA: _____

Employer: _____

Pharmacy Name/Number: _____ Seconday Pharmacy: _____

Height: _____ Weight: _____

Age: _____ Sex (CIRCLE) : Female / Male

Ethnicity/race (CIRCLE): Caucasian (white) African-American Hispanic Asian Other

Your tallest height remembered (late teens or young adult years): _____

Have you noticed a loss in height? YES / NO

What type of exercise do you do daily? _____

Have you had a bone density evaluation in the past? YES / NO

If so, when? _____ Where? _____

Have you ever broken a bone as an adult?: YES / NO

Have you been told that you have osteoporosis or osteopenia? YES / NO

Parent or sibling ever had a broken hip from a simple fall or bump? YES / NO

Parent or sibling had any type of fracture as an adult? YES / NO

Parent or sibling ever been diagnosed with osteoporosis or osteopenia? YES / NO

Have you required treatment with steroids (medications like prednisone, or cortisone)? **NO** or choose one of the four options: Yes, for 2 weeks. YES, for 2 weeks to 3 months. Yes, for more than 3 months.

Yes, **CURRENTLY**, present dose, _____ mg/day.

REVIEW OF SYMPTOMS-Please check ALL items that apply to you.

☐ Weight loss/Gain	☐ Poor Sleep	☐ Bladder Accidents/Incontinene
☐ Fever	☐ Recent Infections	☐ Fatigue
☐ Leg Numbness	☐ Muscle Weakness	☐ Blurred Vision
☐ Stiffness	☐ Swelling	☐ Joint Pain
☐ Dizziness	☐ Difficulty Walking	☐ Mood Changes/Agitation/Anxiety
☐ Visual Difficulties	☐ Other _____	

PAST MEDICAL HISTORY-Please check all that apply.

☐ Anorexia/Bulimia ☐ Hyperparathyroidism ☐ Any Cancers

☐ Celiac Disease/Sprue ☐ GERD ☐ Liver Disease

☐ Diabetes, Type 1 ☐ Hyperthyroidism/Graves ☐ Rheumatoid Arthritis

☐ Gastric/Intestinal Bypass Surgery ☐ Radiation Treatments

☐ Kidney Failure ☐ Conditions Causing Elevated Calcium

PAST SURGICAL HISTORY-Please check all that apply. None

☐ Lumbar Spine/Low Back ☐ Bowel ☐ Extremitites/Arms or Legs

☐ Kidney ☐ Breast ☐ Lung

☐ Prostate ☐ Heart ☐ Gallbladder

☐ Cervical Spine/Neck ☐ Hernia ☐ Hysterectomy

☐ Other (Please specify) _____

MEDICATIONS-List all medications that you take, including injections, pills, patches and creams.

_____	_____	_____
_____	_____	_____

ALLERGIES- Please check ALL medications that apply to you and what reaction you had. ☐ None

☐ Penicillin; Reaction _____ ☐ Sulfa; reaction _____

☐ Iodine; reaction _____ ☐ Codeine; reaction _____

Are you currently or have in the past taken any of the following medications? YES / NO

☐ Fosamax ☐ Actonel ☐ Boniva ☐ Evista ☐ Forteo ☐ Reclast

☐ Estrogen ☐ Tamoxifen ☐ Testosterone ☐ Prolia

Dietary calcium: Do you consume dairy products like milk, yogurt or cheese daily? YES / NO

1-2 servings daily 3-4 servings daily 5 or more servings daily

Do you take CALCIUM SUPPLEMENTS? NO / YES _____ MG/DAY

Do you take VITAMIN D SUPPLEMENTS? NO / YES _____ IU/DAY

Do you take MULTIPLE VITAMIN Daily NO / YES _____ MG/DAY

FOR WOMEN ONLY

I am still having normal menstrual periods at present. YES / NO

I am having periods but they are irregular, because I am approaching menopause. YES / NO

I stopped having periods because of endometrial ablation. YES / NO

I stopped having periods because of hysterectomy, but I still have my ovaries. YES / NO

I had a hysterectomy and my ovaries are removed also at age _____. YES / NO

I stopped having periods because of natural menopause at age _____. YES / NO

FOR MEN ONLY

My doctor has told me that I have low testosterone levels. YES / NO

I have been treated for prostate cancer. YES / NO

I have undergone surgical removal of both testicles. YES / NO

Ever had a bone density test (DXA scan)? YES / NO

FAMILY HISTORY – Please check any disease in your blood relatives.

☐ Cancer ☐ Diabetes ☐ Arthritis ☐ Stroke ☐ Neck/Low Back Pain ☐ Osteoporosis

☐ Other _____

SOCIAL HISTORY – Please answer ALL questions.

Are you: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Do you live: ☐ Alone ☐ With Others _____

Are you: ☐ Employed ☐ Retired ☐ Disabled ☐ Unemployed

If employed, what is your occupation? _____

Is your job,: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy

Are you currently working: Yes / No How long not working? _____

Do you smoke? NO / YES If yes, number of years? _____

Do you drink alcohol? NO / YES If yes, how much per week? _____

Do you drink caffeinated drinks? NO / YES If yes, how much per day? _____

Do you use illegal drugs? NO / YES If yes, how much per week? _____

Highest level of education completed: ☐ High School ☐ College ☐ GED

This history reviewed by: _____ MD/NP/PA Date _____