The Hospital of Central Connecticut

Welcome to the Center for Metabolic Health

OSTEOPOROSIS QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

1. Have you had any Bone Density Scans? Where: _____When: _____

2. Have you had any falls or fractures in the past year? Yes or No
If yes, please describe. _____

   a. Do you use a cane, walker, or assisting device when walking? Yes or No

   b. Do you feel unsteady on your feet? Yes or No

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

Calcium and lifestyle:

	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 <u>most every day</u>.*

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 <u>calcium-added</u> OJ	300		

*For example, cheddar, mozzarella. Do <u>not</u> 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
Multivitamin			
Calcium carbonate			
Calcium citrate			
Vitamin D (plain)	N/A		

Do you have any of the following medical Conditions? Please circle if so.

Thyroid problems Asthma Blood clots Diabetes
Rheumatoid Arthritis Pacemaker Liver disease Breast cancer
Gastrointestinal disorders Epilepsy Kidney disease
Hip/spine surgery or fracture

Have you taken these medications in the past? If yes, please list how many years.

Depo Provera _____Lupron _____ Estrogen_____
Antacids/proton pump inhibitors _____ Dilantin _____
Testosterone _____Cortisone/Prednisone/steroid injections _____

Any other health information you would like to tell us regarding your bone health?

_____
_____
_____
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_____

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