PATIENT HISTORY QUESTIONNAIRE

N	To doub Doto	
Name:	Today's Date:	07.016
Patient ID:	Sex:	OF OM
Current Height: (in)	Date of Birth :	
Weight: (lb)	Referring Physician:	
Menopause Age:	Ethnicity:	
		O O
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		○Yes ○No
from significant trauma (e.g., auto accident)? 3. Did either of your parents ever have a hip fracture?		○Yes ○No
4. Do you smoke?		O Yes O No
5. Have you ever taken Glucocorticoids?		O Yes O No
6. Do you have rheumatoid arthritis?		O Yes O No
7. Do you have secondary osteoporosis?		O Yes O No
8. Do you drink 3 or more alcoholic drinks p	per day?	O Yes O No
9. Are you being treated for osteoporosis?	oci day:	O Yes O No
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10. Have you ever taken any of the following	g medications:	
☐ Actonel (i.e. risedronate)	☐ Boniva (i.e. iba	andronate)
☐ Evista (i.e. raloxifene)		athyroid hormone)
☐ Fosamax (i.e. alendronate)		gen/hormone therapy)
☐ Miacalcin (i.e. calcitonin)		rontium ranelate)
Reclast (i.e. zoledronate)	☐ Prolia (i.e. den	osumab)
☐ Vitamin D	☐ Calcium	
☐ Other - Please specify:		
11. Do you have any of the following medical conditions:		
☐ Anorexia or Bulimia	☐ Any Seizure D	isorders
☐ Asthma or Emphysema	☐ Cancer	
☐ End stage renal disease	☐ Inflammatory l	powel diseases
☐ Hyperparathyroidism	☐ Hysterectomy	
☐ 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 product	s?	○Yes ○No
15. Do you drink caffeinated beverages?		○Yes ○No
If female:		Production of the Park of the
16. At what age did your period start?		
17. Are you premenopausal?		○Yes ○No
18. How many full term pregnancies have yo	ou had?	
19. Have you ever missed your period for me	ore than 6 months in a row	○Yes ○No
(not including pregnancy or menopause)?		O 105 O 110