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SELF-ADMINISTERED QUESTIONNAIRE

Name _____ Date_____

Age_____ Date of Birth_____

Telephone: (Home)_____(Work) _____
(Cell)_____

Email _____

Pharmacy Name _____

Pharmacy Telephone Number _____

Referring Physician: Name: _____
Address: _____
_____
Phone: _____

Primary Physician: Name: _____
Address: _____
_____
Phone: _____

Other Treating Physicians: _____
_____
_____
_____

What are the major concerns or questions you would like answered? _____
_____
_____
_____
_____
_____
_____
_____
_____

FRACTURE HISTORY:

Have you ever had a fracture? Yes_____ No _____
If Yes:

Do you have a history of **fracture(s) in childhood (before age 18)**? Yes_____ No _____
Please list any childhood fractures (bone(s) fractured and age at time of fracture):

_____ _____

_____ _____

_____ _____

Do you have a history of **fracture(s) in adulthood (age 18 or older)**? Yes_____ No _____

Age	**Bone (s) Fractured**	**Activity associated with the fracture event**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OSTEOPOROSIS RISK FACTORS: Please check off all conditions that apply to you:

	YES	NO	COMMENTS
I TEND TO FALL			
I LOST HEIGHT			
I AVOID DAIRY PRODUCTS			
I AVOID SUN EXPOSURE			
I HAVE A FAMILY HISTORY OF OSTEOPOROSIS			
Medical History			
SCOLIOSIS			
EATING DISORDER (anorexia/bulimia)			
SMOKING HISTORY (current or past)			
KIDNEY STONE(S)			
KIDNEY DISEASE			
LIVER DISEASE			
INTESTINAL CONDITION (eg celiac disease, Crohn's disease, prior bariatric surgery)			
INFLAMMATORY DISEASE or INFLAMMATORY JOINT DISEASE (eg rheumatoid arthritis, psoriatic arthritis, lupus)			
PARATHYROID DISEASE			
THYROID DISEASE			
ORGAN TRANSPLANT			
Medication Exposures			
STEROIDS/GLUCOCORTICOIDS (eg prednisone, methylprednisolone, budesonide)			
SEIZURE MEDICATIONS			
HEPARIN OR LOW MOLECULAR WEIGHT HEPARIN			

MENSTRUAL AND REPRODUCTIVE HISTORY (women only)

Age when menses began: _____
Age when menses ended, if applicable: _____
Have you had a Hysterectomy? _____What age?_____
If you had a hysterectomy, were both ovaries removed? YES NO UNSURE
If still menstruating, date of last menstrual period: _____
Menses were/are: (please check one): Regular _____ Irregular_____
Before menopause, is there a history of periods stopping for 6 months or longer when not pregnant or breastfeeding? ___YES ___NO For How long?_____
Number of pregnancies: _____
Number of live births: _____
Did you Breast Feed?: ___YES ___NO For How long?_____
Oral contraceptive use: ___YES ___NO How many years? _____
Hormone therapy use: ___YES ___NO How many years? _____ Date

MEDICAL HISTORY: Please list all of your medical conditions:

DIAGNOSIS	DATE	DOCTOR / HOSPITAL
1)		
2)		
3)		
4)		
5)		
6)		
7)		

***SURGICAL HISTORY**: Please list any operations or procedures you have had:*

SURGERY/PROCEDURE	*DATE*	*DOCTOR / HOSPITAL*
1)		
2)		
3)		
4)		

LIST ALL SERIOUS ALLERGIES TO MEDICATIONS, FOODS, ETC.

_____
_____

CALCIUM AND VITAMIN D: Please list your current use of **Calcium** and **Vitamin D** SUPPLEMENTATION:

	BRAND	**Milligrams of calcium per pill (if known)**	**IU Vitamin D per pill**	**# pills per Day**
Calcium	_____	_____	_____	_____
Multivitamin	_____	_____	_____	_____
Vitamin D	_____	_____	_____	_____

MEDICATIONS: Please list **all** of your **current** medications and dosages: **INCLUDE prescription medications, other vitamins, supplements or over-the-counter medications:**

1)_____ 6)_____

2)_____ 7)_____

3)_____ 8)_____

4)_____ 9)_____

5)_____10)_____

Please list the use (current or past) of any of the following medications:

	YES	**NO**	**If Applicable:**		
			DATE STARTED	**DATE STOPPED**	**Reason medication was stopped**
Fosamax (Alendronate)					
Actonel (Risedronate)					
Boniva (Ibandronate)					
Aredia (Pamidronate)					
Zometa or Reclast (Zoledronate/Zoledronic Acid)					
Prolia or Xgeva (Denosumab)					
Forteo (Teriparatide)					
Tymlos (Abaloparatide)					
Evenity (Romosozumab)					
Miacalcin Nasal Spray					
Evista (Raloxifene)					
Growth hormone treatment					

FAMILY HISTORY:

	Age	Alive	Deceased	Cause of Death	Other Serious Illnesses

Mother: _____
Father: _____
Siblings: _____
Children: _____

Diseases that run in the family:
_____
_____

ADDITIONAL HISTORY:
Birthplace:_____ Marital Status: _____

Who lives with you at home?_____

Occupation:_____

Current tobacco use (# cigarettes/day) _____

Past tobacco use (#cigarettes/day) _____#.years you smoked: _____ Year you quit____

Alcoholic drinks per week:_____

Describe your usual exercise_____

How many cups of caffeinated beverages do you drink per day?_____

Number of daily servings of dairy (milk, cheese, yogurt, etc.)_____

What is your current height _____

What is your current weight _____

What was your maximum height? _____

What was your lowest adult weight? _____ What age? _____

OVERALL REVIEW: Please check off any problems that apply to **YOU:**

CONSTITUTIONAL:

___significant weight loss
___significant weight gain
___fevers/chills
___night sweats
___weakness
___excessive fatigue

EYES/EARS/THROAT:

___loss of vision
___double vision
___tunnel vision
___hoarseness

RESPIRATORY:

___shortness of breath
___chronic cough
___wheezing/asthma

CARDIAC:

___chest pains
___rapid heart beat /palpitations
___ankle/leg swelling

GASTROINTESTINAL:

___loss of appetite
___abdominal pain
___heartburn
___ulcers
___constipation
___diarrhea
___nausea/vomiting

GENITOURINARY:

___frequent urination
___vaginal dryness
___loss of sex drive
___difficulty with erections
___enlarged prostate
___kidney stones

MUSCULOSKELETAL:

___fractures
___back pain
___loss of height
___joint pain
___bone pain
___muscle weakness

DERMATOLOGIC:

___skin rash
___dry skin
___eczema
___psoriasis
___change in skin color

BREAST SYMPTOMS:

___breast pain
___bloody discharge
___milky discharge

NEUROLOGIC:

___poor balance
___tendency to fall
___seizures/epilepsy
___headaches
___dizziness

PSYCHIATRIC:

___depression
___anxiety
___irritability
___sleep disturbance

ENDOCRINE:

___heat intolerance
___hot flashes
___cold intolerance
___excessive thirst
___excessive urination

HEMATOLOGIC:

___bleeding disorder
___anemia
___easy bruising

OTHER:

_____
_____
_____
_____