UW Medicine
NORTHWEST HOSPITAL & MEDICAL CENTER
STRONG BONES PROGRAM

Patient Label

Osteoporosis Patient Questionnaire

Welcome to our clinic! Please bring this completed form to your appointment, along with a list of your current medications and supplements. **Please bring your calcium and vitamin D supplement bottles with you.**

NAME: Last _____ **First** _____ **MI**_____**Gender:** _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Partnered

Occupation: _____ **Retired - Previous Occupation:**_____

Is today's visit: ☐ **Follow-up appointment after hospital stay** ☐ **I was referred**

Who referred you: Please provide his or her name: _____

Medical History	Please check box for those conditions you have now or have ever had

☐ Depression
☐ Eating disorders (anorexia, bulimia)
☐ Celiac disease (gluten intolerance) or chronic diarrhea
☐ Colitis or inflammatory bowel disease (Crohn's, ulcerative colitis)
☐ Reflux or GERD
☐ Seizure disorder
☐ Vertigo or dizziness, lightheadedness
☐ Balance problems or peripheral neuropathy
☐ Parathyroid disease (hyperparathyroidism)
☐ High thyroid disease (hyperthyroidism)
☐ Diabetes

☐ Asthma or other lung problems
☐ Chronic kidney disease
☐ Kidney stones
☐ Rheumatoid arthritis or other types of autoimmune disease
☐ Prednisone or other steroid use daily for > 3 months
☐ Paget's disease ☐ soft tissue ☐ bone
☐ Sarcoid
☐ Cancer (type _____)
☐ Stroke
☐ Organ transplant

Have you lost any height? ☐ Yes ☐ No If so, how many inches? _____

Does osteoporosis run in your family? ☐ Mother ☐ Father ☐ Other

Did your parents ever break a hip? ☐ Yes ☐ No

Do you have any upcoming dental work, tooth extractions, or implants? ☐ Yes ☐ No

Have you had a bone density scan or DEXA? ☐ Yes ☐ No Date of most recent scan: _____
Where was it done? _____

Have you broken any bones after age 50?

☐ Yes ☐ No ☐ I am younger than 50

Date or year the fracture happened	What did you break? Example: hip, wrist, spine, etc.	Did your fracture come from a fall (standing or sitting height)?	Did your fracture come from some other type of accident? Please explain.

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FOR WOMEN

How old were you when your period started? _____

Periods:

- ☐ I still have regular periods
- ☐ I still have irregular periods
- ☐ I have gone through menopause (age or date of last menstrual period: _____)
- ☐ I have had a hysterectomy - Date: _____. My ovaries were ☐ Left in ☐ Taken out

Have you ever missed your period for more than 6 months in a row outside of pregnancy? ☐ Yes ☐ No

FOR MEN

Do you have erectile dysfunction or low sex drive? ☐ Yes ☐ No

Have you ever used testosterone? ☐ Yes ☐ No

PLEASE CHECK (√) IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING OVER THE LAST MONTH

- ☐ Muscle weakness
- ☐ Muscle cramps
- ☐ Unusual/new fatigue
- ☐ Weight loss
- ☐ Fever or Night sweats
- ☐ Swollen glands
- ☐ Loss of appetite
- ☐ Skin rash or hives
- ☐ Eczema or psoriasis
- ☐ Problems with your vision
- ☐ Problems with hearing
- ☐ Headache or migraine
- ☐ Shortness of breath
- ☐ Cough
- ☐ Heart pounding (palpitations)
- ☐ Trouble swallowing
- ☐ Heartburn or stomach gas
- ☐ Diarrhea
- ☐ Problems with urination

Medications	Yes	No	What year (or age) did you take this?	If you have stopped taking this, why?
Alendronate/Fosamax (weekly pill)				
Risedronate/Actonel (weekly or monthly pill)				
Ibandronate/Boniva (monthly pill or IV infusion every 3 months)				
Zoledronate/Reclast (once yearly IV infusion)				
Denosumab/Prolia (every 6 month shot)				
Teriparatide/Forteo (daily shot)				
Raloxifene/Evista (SERMS) (daily pill)				
Calcitonin (nasal spray)				
Hormone replacement therapy (daily pill)				
Estrogen Replacement therapy (daily pill)				
Testosterone				
Lupron				
Femara, Tamoxifen, aromatase inhibitors				

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PLEASE TELL US ABOUT THE MEDICATIONS/SUPPLEMENTS YOU USE. (ATTACH A LIST IF EASIER)

CURRENT MEDICATIONS & SUPPLEMENTS	STRENGTH & NUMBER OF PILLS PER DAY

PLEASE TELL US ABOUT YOUR HABITS:

	Yes	No	
Do you exercise regularly?			Minutes per day: _____ Days per week: _____
Have you fallen in the past year?			How many times? _____
How many cups of coffee/tea/soda do you drink?			Daily: _____ Weekly: _____
Do (or did) you drink alcohol?			Drinks per day: _____ Drinks per week: _____
Do you or have you ever smoked?			Packs per day: _____ Number of years: _____ Quit date: _____

PLEASE TELL US ABOUT YOUR CALCIUM AND VITAMIN D USE

Supplemental Calcium and Vitamin D Sources	Amount Calcium Per Tablet	Amount Vitamin D Per Tablet	Number of Tablets Per Day
Multivitamin			
Calcium Carbonate			
Calcium Citrate			
Calcium (other)			
Vitamin D			

Dietary Calcium	Servings Per Day	Dietary Calcium	Servings Per Day
1 cup milk		Luna Bars (or similar)	
1.5 oz cheese		Fortified orange juice	
6 oz. yogurt		Soy/almond milk	
Green leafy vegetables		Tofu	
Sardines		Cereal (fortified)	