Washington University in St. Louis Physicians

Welcome!

The Bone Health Program
Patient Questionnaire

In order to help our medical team evaluate your health and medical needs, we ask you to provide us with some information about yourself. Please answer the following questions to the best of your knowledge. **Since this document is part of your permanent medical record, all information will be kept strictly confidential.**

Today's Date / /

Patient's Name _____ Date of Birth / / Sex ☐ F ☐ M

Height _____ Weight _____ Your Tallest Height _____ Referring Doctor _____

BONE HEALTH HISTORY

Do you have? ☐ Back Pain ☐ Neck Pain ☐ Arm Pain ☐ Leg Pain

Have you broken any bones?
(other than related to a motor vehicle accident) ☐ No ☐ Yes

If yes, which bones? ☐ Hip ☐ Lower Leg ☐ Lower Arm ☐ Upper Arm ☐ Rib
☐ Vertebra (back) ☐ Pelvis ☐ Other_____

Have you had any major falls? ☐ No ☐ Yes *If yes,* how many in the last year?_____

Have you been diagnosed with: ☐ Osteoporosis ☐ Osteopenia ☐ Low Bone Density

Have you had a previous bone density test done? ☐ No ☐ Yes

If yes, where did you have it done? ☐ This Bone Health Program ☐ BJH Radiology (2nd floor CAM)
☐ Other Center (Please specify where) _____

FOR WOMEN

Have you ever missed your period for longer than 6 months?
(other than during a pregnancy) ☐ No ☐ Yes

Age you got your first period_____

How many pregnancies? _____

How many births? _____

Have you breast-fed? ☐ No ☐ Yes

Have you had a hysterectomy? ☐ No ☐ Yes
If yes, at what age _____

Have you had your ovaries removed (ovariectomy)? ☐ No ☐ Yes
If yes, at what age _____

Have you reached menopause yet? ☐ No ☐ Yes
If yes, at what age _____

LIFESTYLE AND SOCIAL HISTORY

Do you drink alcohol? ☐ Never ☐ Yes *If yes,* how much?_____ per week Drink(s) of choice _____ ☐ Quit

Do you use tobacco? ☐ Never ☐ Yes (if yes, answer ***"Present Use"*** below) ☐ Quit (If quit, answer ***"Past Use"*** below

Present Use

☐ Cigarettes _____ per day for _____years
☐ Cigars _____ per day for _____years
☐ Pipe _____ per day for _____years
☐ Smokeless_____ per day for _____years

Past Use

☐ Cigarettes _____ per day for _____years
☐ Cigars _____ per day for _____years
☐ Pipe _____ per day for _____years
☐ Smokeless_____ per day for _____years

Do you drink caffeine drinks? ☐ No ☐ Yes *If yes:* _____ cups of coffee/day _____ cans of soda/day

Do you exercise by walking or other means at least 20 minutes 3 times per week? ☐ No ☐ Yes

ALLERGIES

_____ _____ _____

_____ _____ _____

FAMILY HISTORY

Please indicate each family member that has been diagnosed with any of the following.

Osteoporosis	☐ mother	☐ father	☐ grandmother	☐ grandfather	☐ sister	☐ brother	☐ daughter	☐ son
Lost Height, Curved Back	☐ mother	☐ father	☐ grandmother	☐ grandfather	☐ sister	☐ brother	☐ daughter	☐ son
Fracture of Hip, Wrist, Spine	☐ mother	☐ father	☐ grandmother	☐ grandfather	☐ sister	☐ brother	☐ daughter	☐ son

MEDICATIONS AND SUPPLEMENTS

	Currently Taking	Previously Taken	Dose	How Long
Actonel (risedronate)	☐	☐		
Arimidex, Aromasin, Femara	☐	☐		
Atelvia(risedronate)	☐	☐		
Boniva (ibandronate)	☐	☐		
Calcium Supplements	☐	☐		
Dilantin, Phenobarbital	☐	☐		
Estrogen (female hormones)	☐	☐		
Evista (raloxifene)	☐	☐		
Forteo (teriparatide)	☐	☐		
Fosamax (alendronate)	☐	☐		
Heparin, Coumadin	☐	☐		
Miacalcin, Fortical (calcitonin)	☐	☐		
Nolvadex, Soltamox (Tamoxifen)	☐	☐		
Prolia (denosumab)	☐	☐		
Reclast, Zometa (zoledronate)	☐	☐		
Steroids (Prednisone)	☐	☐		
Synthroid, Levoxyl (Thyroid Hormone)	☐	☐		
Testosterone (male hormones)	☐	☐		
Vitamin D	☐	☐		

MEDICAL HISTORY Please answer yes or no for each condition

Organ Transplant	☐ No	☐ Yes	Celiac Disease	☐ No	☐ Yes
Bone Marrow Transplant (stem cell)	☐ No	☐ Yes	Chronic Diarrhea	☐ No	☐ Yes
Malabsorption Disorder	☐ No	☐ Yes	Crohn's Disease	☐ No	☐ Yes
Overactive Parathyroid Glands	☐ No	☐ Yes	Asthma	☐ No	☐ Yes
Thyroid Disease	☐ No	☐ Yes	Blood Clot	☐ No	☐ Yes
Kidney Stones	☐ No	☐ Yes	Breast Cancer	☐ No	☐ Yes
Kidney Failure	☐ No	☐ Yes	Prostate Cancer	☐ No	☐ Yes
Chronic Liver Disease	☐ No	☐ Yes	Chemotherapy	☐ No	☐ Yes
Partial or complete removal of stomach	☐ No	☐ Yes	Radiation therapy	☐ No	☐ Yes
Eating Disorders	☐ No	☐ Yes			

MEDICAL HISTORY Please list medical problems not listed above

_____ _____ _____

_____ _____ _____

_____ _____ _____

Patient's Signature Date

Physician's Signature Date

Physicians

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