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PATIENT HISTORY QUESTIONNAIRE

Name: ____ **Today's Date**: ____________________________

Patient ID: _______________________________________ **Gender**: ❑ Female ❑ Male

Current Height (in): ________ **Weight (lbs)**: _________ **Date of Birth**: ____________________________

Age at menopause onset: _______________________________ **Referring Physician**: ______________________

Dominant Hand: ❑ Left ❑ Right **Ethnicity/Race**: ______________________________

1. Have you had a previous hip or lumbar spine fracture/surgery? ❑ Yes ❑ No
2. Have you had any fractures during your adult life which were not caused by significant trauma (e.g., auto accident)? ❑ Yes ❑ No
3. Did either of your parents ever have a hip fracture? ❑ Yes ❑ No
4. Do you smoke? ❑ Yes ❑ No
5. Have you ever taken oral steroids for an extended period of time? ❑ Yes ❑ No
6. Do you have rheumatoid arthritis? ❑ Yes ❑ No
7. Do you have osteoporosis caused by any other disease or condition? ❑ Yes ❑ No
8. Do you drink 3 or more alcoholic drinks per day? ❑ Yes ❑ No
9. Are you currently being treated for osteoporosis? ❑ Yes ❑ No

10**. Place a check in the box if you are taking or have ever taken any of the following medications:**

- ❑ Actonel (i.e., risedronate)
- ❑ Evista (i.e., raloxifene)
- ❑ Fosamax (i.e., alendronate)
- ❑ Miacalcin (i.e., calcitonin)
- ❑ Reclast (i.e., zoledronate)
- ❑ Vitamin D
- ❑ Boniva (i.e., ibandronate)
- ❑ Forteo (i.e., parathyroid hormone)
- ❑ HRT (i.e., estrogen/hormone therapy)
- ❑ Protelos (i.e., strontium ranelate)
- ❑ Prolia (i.e., denosumab)
- ❑ Calcium
- ❑ Other (Please Specify): ____________________________

11. **Place a check in the box if you have or have had any of the following medical conditions:**

- ❑ Anorexia or Bulimia
- ❑ Asthma or Emphysema
- ❑ End stage renal disease
- ❑ Hyperparathyroidism
- ❑ Any Seizure Disorders
- ❑ Cancer
- ❑ Inflammatory bowel diseases
- ❑ 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 products? ❑ Yes ❑ No
15. Do you drink caffeinated beverages? ❑ Yes ❑ No

If Female:

16. At what age did your menses (periods) start? ___________
17. Are you **pre-**menopausal? ❑ Yes ❑ No
18. How many full term pregnancies have you had? ___________
19. Have you ever missed your period for more than 6 months in a row? ❑ Yes ❑ No
    (other than during pregnancy/nursing or menopause)