



BONE HEALTH HISTORY

Social Security Number _____ Last Name _____ First Name _____

Date of Birth _____

Yes No Is there any chance that you are pregnant?

Yes No Have you had a nuclear medicine scan or injection of an x-ray dye in the last week?

Yes No Have you had hyperparathyroidism or high calcium level in your blood?

What is your ethnicity? Caucasian (White) Black Aboriginal Asian Hispanic Other _____

What is your country of birth? _____

Have you ever had a bone density test? Yes No If yes, when and where? _____

What is your current weight in pounds? _____

Have you had a recent weight change? Yes No If yes, tell us about it: _____

Your tallest height (late teens or young adult): _____ feet _____ inches

Have you ever broken a bone?

Broken Bone	Was this a simple fall?	If not a simple fall, please describe the circumstances	Age when fracture occurred

Yes No Have either of your parents fractured a hip?

Yes No Have they fractured other bones from a fall?

Yes No Has a grandparent, sister, brother, aunt, or uncle fractured a hip?

Yes No Have any direct relatives had osteoporosis? If so, which relative? _____

Are you currently receiving or have you previously received prednisone pills (cortisone)?

Yes, currently Yes, previously No, never

If yes, for how long? _____ What is your dose? _____ mg, or _____ pills each day.

Do you have Rheumatoid Arthritis, Lupus, Crohn's or other autoimmune disease? Yes No If yes, which condition(s)? _____

List any other chronic medical conditions that you have: _____

Have you been treated with any of the following medications?

Medication	Ever?	Currently?	If current, how long?
Hormone replacement therapy (Estrogen)			
Tamoxifen			
Raloxifene (Evista)			
Testosterone			
Calcitonin (Malcacin nasal spray)			
Alendronate Generic			
Alendronate (Fosomax brand)			
Risendronate (Actonel)			
Ibandronate (Boniva) pills			



Medication	Ever?	Currently?	If current, how long?
Ibandronate (Boniva) IV			
Zoledronic acid (Reclast) IV			
Zoledronic acid (Zometa) IV			
Pamidronate (Aredia) IV			
Denosumab (Prolia)			
PTH (Forteo)			

Have you ever:

- Yes No Had cancer?
- Yes No Taken chemotherapy for cancer?
- Yes No Taken other medication for cancer?
- Yes No Taken radiation for cancer?
- Yes No Taken medication to prevent organ transplant rejection?

How many servings of the following do you eat/drink per day (on average)?

	Milk (full cup)	Orange juice fortified with calcium (full cup)	Yogurt (small container or 1/2 cup)	Cheese
# of Servings				

What calcium supplements do you take? _____

What vitamin D supplements do you take? _____

What other vitamin supplements do you take? _____

FOR WOMEN ONLY:

- Yes No Are you still having menstrual periods?
- Yes No Before menopause, have you ever missed your periods for 6 months or more, besides during pregnancy?
- Yes No Have you had your menopause? If yes, at what age? _____
- Yes No Have you had a hysterectomy? If yes, at what age? _____
- Yes No Have you had both of your ovaries removed? If yes, at what age? _____

The information on this form is accurate to the best of my knowledge. This form is destroyed after the information is entered and verified in the patient's electronic health record.

Patient Signature: _____ Date: _____