PHYSICIANS' CLINIC
of Iowa, P.C.

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 barium x-ray in the last 2 weeks?

☐ 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 hyperparathyroidsim or high calcium level in your blood?

If you answered 'Yes' to any of the above, speak to our receptionist right away.

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 (Malcalcin nasal spray)			
Alendronate Generic			
Alendronate (Fosomax brand)			

Medication	Ever?	Currently?	If current, how long?
Risendronate (Actonel)			
Ibandronate (Boniva) pills			
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.

Patient Signature: _____ Date: _____