

Osteoporosis Questionnaire



Name: _____ Date: _____

Age: _____ Sex: _____ Race: _____ Ethnic Background: _____

Mature Adult Height: _____ Office use only: Current Height: _____ Weight: _____

Osteoporosis History:

Have you ever had a bone density test before? Yes: _____ No: _____

If yes, when and where did you have it? _____

Did your previous bone density scan diagnose you with osteopenia or osteoporosis? Yes: _____ No: _____

Are you currently on any medications for osteoporosis? (Circle) Fosamax 35mg, Fosamax 70mg, Fosamax 70mg + Vit D (2800), Fosamax 70mg + Vit D (5600), Actonel 35mg, Actonel 75mg, Miacalcin, Fortical Nasal Spray, Estrogen, Evista, Boniva 150mg, Boniva 3mg IV, Reclast IV, or Forteo.

Have you discontinued any osteoporosis medications? Yes: _____ No: _____ If yes, list name of medication and why you discontinued it. _____

Do you have a family history of osteoporosis? Yes: _____ No: _____

Bone Fracture History:

Have you ever fractured or broken a bone after the age of 40 yrs? Yes: _____ No: _____

If yes, was it a fragility/stress fracture or traumatic fracture due to injury (circle).

Menstrual History:

Age of first period: _____ Are you still menstruating? Yes: _____ No: _____

If yes, are your periods regular or irregular? (Circle). If no, age of onset of menopause _____.

Was menopause natural or did you have surgical removal of your uterus and/or ovaries? (Circle)

Do you have symptoms associated with menopause, such as hot flashes, sleeplessness, headache, or lack of concentration? Yes: _____ No: _____.

If menopausal, were you started on hormones (estrogen, or estrogen and progesterone)?

If yes, how soon after menopause did you start taking hormones? _____ Are you still taking hormones? Yes: _____ No: _____. If not how long did you take them before stopping? _____

Have you ever or are you currently taking any hormone suppressing agents? (ie: Lupron, Depo Provera) Yes: _____ No: _____ If yes, how long? _____

Medication History:

Current, long term or past use of steroid therapy (prednisone, orisone, deltasone, solumedrol, etc.)?

Yes: _____ No: _____. If yes please explain _____

Antiseizure drugs such as Dilantin or Phenobarbital over 5 years? Yes: _____ No: _____

PLEASE CONTINUE ON THE BACK

Technician comments:

Sponge : 0 1 2 3

Authorization for follow-up: Yes _____ No _____

Name: _____ D.O.B. _____ Date: _____

Medical History:

Have you ever had or currently having any of the following health problems? Please check or answer below.

Back pain _____	Stomach disorders _____	Diabetes (Insulin dependent) _____
Back surgeries (type) _____	Esophageal disorders _____	Heart disease _____
Bone pain _____	Chronic Diarrhea _____	Liver disease _____
Osteoarthritis _____	Gastrectomy _____	Lung disease _____
Rheumatoid Arthritis _____	Ulcerative Colitis _____	Kidney disease _____
Autoimmune disease _____	Eating disorder _____	Dementia _____
Thyroid disease _____	Cancer (type) _____	Vitamin D deficiency _____
Hyperparathyroidism _____	Chemo/Radiation _____	Frequent falls _____
Crohn's disease _____	Blood clots _____	Other _____

Exercise History:

How often do you exercise? _____

What type of exercise do you usually do? _____

Smoking:

Do you smoke? Yes: _____ No: _____ If yes, how many packs per day? _____

How many years? _____ If you quit, when did you quit? _____

Caffeine/ Alcohol:

How many ounces of caffeinated beverages do you drink per day? _____

Do you drink alcohol on a daily basis? Yes: _____ No: _____

If yes, how many drinks per day? _____

Calcium and Vitamin D Assessment:

How many servings of calcium rich foods do you average per day? _____

Do you take a calcium supplement? Yes: _____ No: _____

If yes, please include the brand name, amount of calcium in each tablet, and how many you take daily. If your calcium includes vitamin D or you get it from another source, please include that information too.

SUPPLEMENT: _____

Medication List

Name: _____ Date: _____

Please list below your current prescription medications.

Name of medication and dosage	How often	Start date	Reason
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1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

13. _____

14. _____

15. _____

16. _____

17. _____

18. _____

19. _____

20. _____

WELCOME TO THE BEALS INSTITUTE

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Beals Institute to release any medical or incidental information that may be necessary for either medical care or in processing applicants for financial benefits.

ASSIGNMENT OF INSURANCE BENEFITS

- I hereby direct payment of surgical/medical benefits to the Beals Institute for services rendered by him/her in person or under his/her supervision.
- I understand that I am financially responsible for any balance not covered by my insurance.
- I certify that the information given by me on the pages below is current and correct.
- I request that payment of authorized benefits be made on my behalf.
- I have reviewed and agree with the Beals Institute privacy practices.

BONE DENSITY FOLLOW UP VISIT

Bone density follow up counseling appointments are billed as a separate office call. The fee for these appointments are not included in the bone density scan charge.

Patient (please print) _____

Patient (signature) _____ Date _____

Parent/Guardian _____ Date _____