# Northwest Osteoporosis Center

## Medical History Questionnaire

**Name: ________________________________ Age: ______________ Date: ______________________**

**Referred By: ___________________________ Gender: M F Scan No: _______________________**

**Wt. _________ Ht. __________ Birthdate: __________________**

**Ethnic Background: ❑ Caucasian ❑ African American ❑ Asian ❑ Hispanic**

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Why has your referring physician sent you here? _______________________________________________

Have you lost height? ❑ Yes ❑ No

If so, by how many inches? ___________

Are you a current smoker? ❑ Yes ❑ No

Have you fractured your hip, back, shoulder or wrist as an adult? ❑ Yes ❑ No

If so, please describe how the fracture occurred (eg: fall, accident etc.) and at what age?

_________________________________________________________________________

Have either of your parents fractured a hip? ❑ Yes ❑ No

Do you have a family history of osteoporosis? ❑ Yes ❑ No

Are you currently on a steroid medication (prednisone, cortisone, dexamethasone, solumedrol)? If yes, what dose_______________? ❑ Yes ❑ No

Have you ever been on 5 mg. per day or higher of prednisone for over 3 months? ❑ Yes ❑ No

Do you have a known diagnosis of any of the following:

- Rheumatoid Arthritis ❑ Yes ❑ No
- Untreated hyperthyroidism (overactive thyroid) ❑ Yes ❑ No
- Early menopause (before age 45) ❑ Yes ❑ No
- Insulin dependent diabetes (Type I) ❑ Yes ❑ No
- Chronic liver disease ❑ Yes ❑ No
- Low testosterone or low estrogen levels ❑ Yes ❑ No
- Celiac disease ❑ Yes ❑ No

Have you had any hip or back surgery? ❑ Yes ❑ No

Do you currently consume more than 3 alcoholic beverages a day? ❑ Yes ❑ No

Have you had any nuclear or barium testing recently? ❑ Yes ❑ No

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*Please list all current medications and supplements. Include milligrams & length of time taking each.*

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

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*Have you ever taken any of the following medications?*

Thyroid ❑ Yes ❑ No Prednisone ❑ Yes ❑ No Miacalcin ❑ Yes ❑ No Fosamax ❑ Yes ❑ No

Estrogen ❑ Yes ❑ No Cortisone ❑ Yes ❑ No Boniva ❑ Yes ❑ No Dilantin ❑ Yes ❑ No

Actonel ❑ Yes ❑ No Evista ❑ Yes ❑ No Forteo ❑ Yes ❑ No Reclast ❑ Yes ❑ No

Tegretol ❑ Yes ❑ No

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*Which of the following do you consume on a daily basis?*

❑ Milk, 8 oz (350mg) How many glasses per day? ____________

❑ Yogurt, 8 oz. Indicate which type: ❑ Fruit ❑ Plain
(300 mg) (400 mg)

❑ Cheese, 1 oz (200 mg)

❑ Cottage Cheese, 4 oz (60 mg)

❑ Ice Cream or Frozen Yogurt, 8 oz. (175 mg)

❑ Broccoli,1/2 C (60 mg); Dried Beans 1/2 C (60 mg); Orange, 1 med. (60 mg)

❑ Whole Wheat Bread (25 mg) Slices per day? ___________

❑ Instant Oatmeal, 1 packet (100 mg)

❑ Calcium Fortified Cereal, ( 3/4 C cereal with 1/2 C milk 300 mg).

❑ Calcium Fortified Orange Juice, 8 oz (300 mg)

❑ Calcium Fortified Rice or Soymilk, 8 oz (300 mg)

❑ Tofu (calcium set), 1/2 cup (300 mg)

_______________________
*Total Dietary Calcium*

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Do you take a calcium supplement? If yes, total milligrams per day: ________________ ❑ Yes ❑ No

Does the product contain vitamin D? If yes, amount: ______________________ ❑ Yes ❑ No

Are you taking a vitamin D supplement? If yes, amount:____________________ ❑ Yes ❑ No

Are you taking a multi-vitamin? ❑ Yes ❑ No

*Total Vitamin D* _________________ *Total Calcium* ______________________

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Are you post-menopausal? If yes, what age? __________________ ❑ Yes ❑ No

Have you had a hysterectomy? If yes, what age? __________________ ❑ Yes ❑ No

Have you had your ovaries removed? If yes, what age? ___________________ ❑ Yes ❑ No

Have you ever taken estrogen replacements? If yes, how long? _____________ ❑ Yes ❑ No

Have you ever had prolonged absence of periods other than child-birth or menopause? ❑ Yes ❑ No

Do you exercise? If yes, what and how often? __________________________________________ ❑ Yes ❑ No

Have you ever had an eating disorder? ❑ Yes ❑ No