

OA Osteoporosis Clinic – New Patient Questionnaire

Welcome to our clinic! Please complete this form along with a list of your current medications and supplements (or bring all your medication bottles) to your appointment.

Patient Name: _____ Date of Birth: _____ Age: _____

Have you broken any bones after age 50? YES / NO

Bone	Date	How did it happen (ex. car accident, fall, etc.)?

Prior diagnosis of osteoporosis or osteopenia? YES / NO

When was your last DEXA (bone density) scan? Date: _____
T Score: _____

Have you taken any of these medications (now or in the past)?

Medication	Yes	No	Dates: ____ to ____	If you have stopped, why?
Alendronate/Fosamax				
Risedronate/Actonel				
Ibandronate/Boniva				
Zoledronate/Reclast				
Denosumab/Prolia				
Teriparatide/Forteo				
Raloxifene/Evista				
Calcitonin/Fortical or Miacalcin				
Estrogen				

Do you take calcium supplements? YES / NO

Do you take vitamin D supplements? YES / NO

Do you take oral steroids (ex. Prednisone) regularly? YES / NO

Women's Reproductive History:

Do you still have periods? YES / NO

If yes, they are: REGULAR/IRREGULAR

Age or date of last menstrual period: _____

Have you used hormone replacement/estrogen therapy?

YES / NO

Date: _____ to _____

Prior Surgeries:

Have you had any of the following gynecologic surgeries?

Bilateral oophorectomy (removal of both ovaries)

YES / NO

Date: _____

Total hysterectomy including removal of both ovaries YES / NO

Date: _____

Have you had a gastric bypass?

YES / NO

Date: _____

Other _____ surgeries:

Personal Medical History:

Condition	Yes	No	Do you see a specialist for this?
Parathyroid disease			
Thyroid disease			
Kidney disease			
GERD/Reflux			
Esophageal disorder			
Stomach ulcers			
Heart condition Specify: _____			
Stroke			
Osteoporosis			
Celiac disease			
Cancer (type _____)			

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For patients with a history of cancer:

Year of diagnosis: _____

Circle the following that you received: Surgery / Radiation / Chemotherapy

If breast cancer:

Did you receive Tamoxifen? YES / NO

Date: _____ to _____

Did you receive Aromatase inhibitor?

YES / NO

Date: _____ to _____

Family History:

Does osteoporosis run in your family? Mother / Father / Other(s) _____

Has either of your parents broken a hip? Mother / Father

Social History:

Do you exercise regularly? YES / NO

_____ minutes per day _____ days per week

Do you use a: Cane / Walker / Wheelchair / Other

Have you fallen within the last year?

YES / NO

Do you smoke? Yes / Former / Never

_____ packs/day x _____ years. If quit, when? _____

Alcohol: _____ drinks per week

Drugs: Marijuana / Cocaine / Opiates / Other

Review of Systems: Are you experiencing any of the following:

fever/ chills/ fatigue/ weight loss/ frequent falls

rashes/ wounds/ itching

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Destin

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vision changes/ hearing changes
chest pain/ palpitations/ pain with breathing
cough/ wheezing/ shortness of breath
nausea/ vomiting/ diarrhea/ constipation/ heartburn
pain with urination / incontinence
leg swelling / calf pain/ easy bruising
joint pain / muscle aching / back pain / stiffness
headaches / numbness and tingling / weakness

ANYTHING ELSE WE SHOULD KNOW ABOUT YOU?

Patient Signature (or guardian/representative)

Date