PATIENT HISTORY QUESTIONNAIRE

Name: **Today's Date:**
Patient ID: **Sex:** ○F ○M
Current Height: (in) **Date of Birth :**
Weight: (lb) **Referring Physician:**
Menopause Age: **Ethnicity:**

1. Have you had a previous hip or vertebral fracture? ○Yes ○No
2. Have you had any fractures during your adult life which did not result from significant trauma (e.g., auto accident)? ○Yes ○No
3. Did either of your parents ever have a hip fracture? ○Yes ○No
4. Do you smoke? ○Yes ○No
5. Have you ever taken Glucocorticoids? ○Yes ○No
6. Do you have rheumatoid arthritis? ○Yes ○No
7. Do you have secondary osteoporosis? ○Yes ○No
8. Do you drink 3 or more alcoholic drinks per day? ○Yes ○No
9. Are you being treated for osteoporosis? ○Yes ○No

10. Have you ever taken any of the following medications:
    - ☐Actonel (i.e. risedronate)
    - ☐Boniva (i.e. ibandronate)
    - ☐Evista (i.e. raloxifene)
    - ☐Forteo (i.e. parathyroid hormone)
    - ☐Fosamax (i.e. alendronate)
    - ☐HRT (i.e. estrogen/hormone therapy)
    - ☐Miacalcin (i.e. calcitonin)
    - ☐Protelos (i.e. strontium ranelate)
    - ☐Reclast (i.e. zoledronate)
    - ☐Prolia (i.e. denosumab)
    - ☐Vitamin D
    - ☐Calcium
    - ☐Other - Please specify:
11. Do you have any of the following medical conditions:
    - ☐Anorexia or Bulimia
    - ☐Any Seizure Disorders
    - ☐Asthma or Emphysema
    - ☐Cancer
    - ☐End stage renal disease
    - ☐Inflammatory bowel diseases
    - ☐Hyperparathyroidism
    - ☐Hysterectomy
    - ☐Other - Please specify:
12. What was your maximum height (inches)?
13. Do you perform weight bearing exercise regularly? ○Yes ○No
14. Do you regularly consume dairy products? ○Yes ○No
15. Do you drink caffeinated beverages? ○Yes ○No

If female:

16. At what age did your period start?
17. Are you premenopausal? ○Yes ○No
18. How many full term pregnancies have you had?
19. Have you ever missed your period for more than 6 months in a row (not including pregnancy or menopause)? ○Yes ○No