PATIENT HISTORY QUESTIONNAIRE

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

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

10. Have you ever taken any of the following medications:

- ☐ Actonel (i.e. risedronate)
- ☐ Evista (i.e. raloxifene)
- ☐ Fosamax (i.e. alendronate)
- ☐ Miacalcin (i.e. calcitonin)
- ☐ Reclast (i.e. zoledronate)
- ☐ Vitamin D
- ☐ Other - Please specify:
- ☐ Boniva (i.e. ibandronate)
- ☐ Foreto (i.e. parathyroid hormone)
- ☐ HRT (i.e. estrogen/hormone therapy)
- ☐ Protelos (i.e. strontium ranelate)
- ☐ Prolia (i.e. denosumab)
- ☐ Calcium

11. Do you have any of the following medical conditions:

- ☐ Anorexia or Bulimia
- ☐ Asthma or Emphysema
- ☐ End stage renal disease
- ☐ Hyperparathyroidism
- ☐ Other - Please specify:
- ☐ Any Seizure Disorders
- ☐ Cancer
- ☐ Inflammatory bowel diseases
- ☐ Hysterectomy

12. What was your maximum height (inches)?
13. Do you perform weight bearing exercise regularly? o Yes o No
14. Do you regularly consume dairy products? o Yes o No
15. Do you drink caffeinated beverages? o Yes o No

If female:

16. At what age did your period start?
17. Are you premenopausal? o Yes o 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)? o Yes o No