Osteoporosis/Osteopenia/Calcium Abnormality Intake Questionnaire

Patient Name: _____ Date of Birth: _____

Self-referral or referred by: _____ Reason for referral: _____

Prior endocrinologist (if any): _____

Please bring this completed form along with a list of your current medications and supplements (or bring all your medication bottles) to your appointment.

1) **What are you here for today? _____**
2) **When were you first diagnosed? _____**
3) **What treatment was initially advised? _____**
4) **Have you had any fractures in the past?** ____Yes or ____No. If yes, answer below:

Fracture of what bone?	Date of fracture	How did it happen?	Treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5) **Are you taking or have you taken any of these medications?**

Medication	Yes	No	When to when?	Why stopped?
Alendronate (Fosamax)	____	____	_____	_____
Risedronate (Actonel)	____	____	_____	_____
Ibandronate (Boniva)	____	____	_____	_____
Zoledronate (Reclast)	____	____	_____	_____
Denosumab (Prolia)	____	____	_____	_____
Teriparatide (Forteo)	____	____	_____	_____
Abaloparatide (Tymlos)	____	____	_____	_____
Raloxifene (Evista)	____	____	_____	_____
Estrogen	____	____	_____	_____
Testosterone	____	____	_____	_____
Prednisone or any another form of steroids? or steroid injections?	____	____	_____	_____

6) **Dietary Calcium Intake**

Sources of calcium	Servings per day
1 cup of milk	_____
6 oz of yogurt	_____
1.5 oz of cheese (ex. Cheddar, mozzarella)	_____
1 cup of calcium - added Orange Juice	_____

7) Are you taking any of these?

Supplements	Yes	No	Dose	Number of tablets per day
Multivitamin	____	____	_____	_____
Calcium Citrate	____	____	_____	_____
Calcium Carbonate	____	____	_____	_____
Vitamin D	____	____	_____	_____

8) Symptom review

	Yes	No	Comments
Do you have chronic diarrhea?	____	____	_____
Do you have problems with balance?	____	____	_____
Do you have problems with vision?	____	____	_____
Have you had an irregular heart rhythm?	____	____	_____
Do you have heartburn/reflux symptoms?	____	____	_____
Do you have any dental procedures planned?	____	____	_____
For men: Do you have ED or low sex drive?	____	____	_____
For women: Are you still having periods?	____	____	If yes, Regular___ Irregular___
For women: Have you had menopause?	____	____	If yes, approximate date/year of last period? _____

9) Medical history

Do you have a history of	Yes	No	Comments
Kidney stones?	____	____	_____
High calcium levels?	____	____	_____
Low calcium levels?	____	____	_____
Thyroid disease?	____	____	_____
Parathyroid disease?	____	____	_____
Organ transplant?	____	____	If yes, which organ and when? _____
Gastrointestinal surgery?	____	____	_____
Seizures?	____	____	_____
Cancer?	____	____	If yes, have you have radiation? _____

10) Social history

	Yes	No	Details
Do you exercise regularly?	____	____	_____ minutes per day _____ days per week
Do you have a history of falling?	____	____	If yes, how many times a month? _____
Do you drink coffee or soda?	____	____	_____ drinks per day / week
Do you (or did) you smoke?	____	____	___ packs per day for ___ years. Quit date ____
Do you drink alcohol?	____	____	_____ drinks per day / week

11) **Does osteoporosis run in your family**? ☐ Mother ☐ Father ☐ Other(s)_____

b) Has either of your parents broken a hip? ☐ Yes ☐ No