Fracture Liaison Clinic

Pre-Visit Questionnaire (In-Take Form)

Name: ______________________________ Date: ___________________________

1. How did you learn about this program?
   - ☐ Primary care physician; please list physician's name: _______________________
   - ☐ Other: _______________________
2. Have you experienced height loss after age 29? ☐ Yes ☐ No
   - If so, in your best estimate, how many inches have you lost?_______________
3. If you are female, are you still menstruating? ☐ Not Applicable ☐ Yes ☐ No
   - Have you had your ovaries removed via surgical hysterectomy? ☐ Yes ☐ No
   - If so, at what age was your surgery? _______________________
   - If you did not have your ovaries removed via surgical hysterectomy and you have completed menopause, at what age was your last period? _______________________
4. If you are male, are you aware if you have low testosterone?
   ☐ Not Applicable ☐ Yes ☐ No
5. Have you ever taken hormone replacement therapy? ☐ Yes ☐ No
6. Are you a: ☐ Vegetarian ☐ Vegan ☐ Neither
7. Do you currently smoke? ☐ Yes ☐ No
   - Have you ever smoked? ☐ Yes ☐ No
8. Do you drink alcohol? ☐ Yes ☐ No
   - If yes, how many drinks do you have per week? ____________
9. Have you fallen more than twice in the past year? ☐ Yes ☐ No
10. How active have you been in the last 12 months prior to your injury?
    - ☐ Not able to walk
    - ☐ Not active (walking less than a mile a day)
    - ☐ Somewhat active (walking some, but less than 2 miles per day)
    - ☐ Very active (walking 2 or more miles per day)

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11. How many caffeinated beverages do you drink in one day (1 serving = 8 oz)
    - ☐ No caffeinated beverages
    - ☐ Less than 3 servings a day
    - ☐ More than 3 servings a day
12. Did either of your parents have a hip fracture after the age of 50 or do you have any family history of osteoporosis? ☐ Yes ☐ No
13. Have you ever been diagnosed with any of the following diseases or disorders? (Check all that apply).
    - ☐ Rheumatoid Arthritis
    - ☐ Lupus
    - ☐ Celiac Disease or Absorption Disorder
    - ☐ Gastric Bypass
    - ☐ COPD
    - ☐ GERD
    - ☐ Hyperparathyroidism
    - ☐ Hypothyroidism
    - ☐ Diabetes
    - ☐ Kidney Stones
    - ☐ Seizure Disorder
    - ☐ HIV/AIDS
    - ☐ Hepatitis B or C
    - ☐ Paget's Disease
14. Do you currently have a fracture? ☐ Yes ☐ No
    - If so, what bone is fractured? _______________On what date did the injury occur?__________
15. If you currently have a fractured bone, have you broken any other bones since turning age 50?

    ☐ Yes ☐ No
    - If yes, please list all: ____
16. Have you had a bone density scan or DEXA scan in the past 2 years?

    ☐ Yes ☐ No
    - If yes, where and when: ____

      ____

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17. Are you currently or have you ever taken any of the following medications? If yes, please indicate the duration for each.

    □ Fosamax (Aldendronate) ____________________

    □ Didronel (Etidronate) ____________________

    □ Boniva (Ibandranate) ____________________

    □ Aredia (Pamidronate) ____________________

    □ Actonel (Risedronate) ____________________

    □ Reclast (Zoledronate) ____________________

    □ Fortical (Calcitonin) ____________________

    □ Miacalin (nasal spray) ____________________

    □ Evista (Raloxifene) ____________________

    □ Forteo (Teriparatide) ____________________

    □ Prolia (Denosumab) ____________________

    □ Anticonvulsants (Gabapentin, Lyrica or Lamictal) ____________________

    □ Anticoagulants (Heparin, Warfarin) ____________________

    □ Opioids (Oxycodone/Oxycontin) ____________________

    □ Oral Steroids (Prednisone) ____________________

    □ PPI's (Omeprazole, Prilosec or Nexium) ____________________

    □ SSRI's (Lexapro, Celexa or Sertaline) ____________________

18. Have you ever had high or low calcium levels? □ Yes □ No
19. Have you ever had low vitamin D levels? □ Yes □ No
20. Are you taking any nutritional supplements (if so, please list the dose and duration):

    Calcium □ Yes □ No

    If yes, what dose and for how long? ____________________

    Vitamin D □ Yes □ No

    If yes, what dose and for how long? ____________________

21. Have you ever been treated for cancer with high beam radiation or had radioactive implants?

    □ Yes □ No If yes, what type? ____________________