CEDAR VALLEY BONE HEALTH INSTITUTE

Bone Health Follow-Up Medical Questionnaire

Date _____ EHR # _____

Patient Name _____

1.) Is there a new problem that was not evaluated at your last visit? [ ] Y [ ] N, if so what is it? _____

2.) How long since your last visit? _____ [ ] days [ ] months [ ] years

3.) What Calcium supplement are you taking? _____

4.) What Vitamin D supplement are you taking? _____

5.) What other Vitamins are you taking? _____

6.) What Osteoporosis medicine are you taking? _____

7.) Are you having any problems with your medications? _____

Describe the problems. _____

_____

8.) Have you had lab work done since your last visit? Where? _____

When? _____

9.) Do you have any questions that need to be answered at this visit? _____

_____

_____

INTERVAL HISTORY: Since your LAST VISIT have you:

10.) Developed any NEW problems? Please circle which area(s): GERD / Bowels Anemia Diabetes BP / Heart Allergies Weight loss or Gain Muscles / Joints Skin Eyes, Ears, Nose, Throat

11.) Been Hospitalized? When, Where, Why? _____

12.) Been prescribed NEW Medication by another physician? _____

13.) Discontinued any of your Medications? _____

14.) Changed your living situation? How? _____

15.) Made any other changes? _____

Patient Signature_____ Date _____

MD/NP Signature_____ Date _____