



Patient Questionnaire

Name (print): _____ Date: _____

- Is there any chance that you are pregnant? Yes No
 Have you had a barium X-ray in the last 2 weeks? Yes No
 Have you had a nuclear medicine scan or injection of an X-ray dye in the last week? Yes No
 Have you had hyperparathyroidism or a high calcium level in your blood? Yes No

If you have answered any of the above, speak to our receptionist right away.

1. Your Age: _____ Sex: Male Female

2. Your Ethnicity (check one):

Caucasian (White) Black Aboriginal Asian Hispanic Other: _____

Your country of birth: _____

3. Have you ever had a bone density test? Yes No

If yes, when and where? _____

4. What is your current weight? _____ lbs.

Have you had a recent weight change? Yes No

If yes, tell us about it: _____

5. Your tallest height (late teens or young adult): _____

6. Have you ever broken a bone?

Broken Bone	Simple Fall?	If not a simple fall, please describe the circumstances	Age when this occurred

7. Has a parent fractured a hip? Yes No

Other bones from a fall from a standing height? Yes No

8. Has a grandparent, sister, brother, aunt, or uncle fractured a hip? Yes No

9. Do you smoke? Yes No

10. Are you currently receiving or have you previously received prednisone pills (cortisone)?

Yes, currently _____ Yes, previously _____ No _____

If yes, for how long? _____ What is your dose? _____ mg, or _____ pills each day.

11. Do you have Rheumatoid Arthritis, Lupus, Crohn's, other Autoimmune disease? Yes No

12. List any chronic medical conditions that you have: _____



17. How many servings of the following do you eat/drink per day (on average)?

	Milk (full cup)	Orange Juice fortified with calcium (full cup)	Yogurt (small container or 1/2 cup)	Cheese
Number of Servings				

18. What calcium supplements do you take?

19. What vitamin D supplements do you take?

20. What other vitamin supplements do you take?

For women only...

21. Are you still having menstrual periods? Yes No

22. Before menopause, have you ever missed your periods for 6 months or more, besides during pregnancy? Yes No

23. Have you had your menopause? Yes No
 If yes, at what age? _____

24. Have you had a hysterectomy? Yes No
 If yes, at what age? _____

Have you had both of your ovaries removed? Yes No
 If yes, at what age? _____

REVIEW OF SYSTEMS:

CIRCLE ANY CONDITION BELOW THAT YOU HAVE OR CHECK NONE

System	Conditions:			None	Describe
M/S	Rheumatoid Arthritis	Gout	Back Pain	<input type="checkbox"/>	
	Osteoporosis	Fracture: Which bone? _____			
GI	Heartburn	Ulcers	Nausea	<input type="checkbox"/>	
	Vomiting	Blood in stool			
ENDO	Frequent Thirst	Frequent Urination	Always Hot or Cold	<input type="checkbox"/>	
CONST	Weight Loss	Frequent Fever	Loss of appetite	<input type="checkbox"/>	
EYE	Blurred Vision	Double Vision	Vision Loss	<input type="checkbox"/>	
ENT	Hearing Loss	Hoarseness	Trouble swallowing	<input type="checkbox"/>	
C-VASC	Chest Pain	Palpitations		<input type="checkbox"/>	
RESP	Chronic Cough	Shortness of Breath		<input type="checkbox"/>	
GU	Painful Urination	Blood in Urine	Kidney Problems	<input type="checkbox"/>	
SKIN	Frequent Rashes	Skin Ulcers	Psoriasis	<input type="checkbox"/>	
NEURO	Headaches	Dizziness	Seizures	<input type="checkbox"/>	
PSYCH	Drug/Alcohol Problem	Depression	Sleep Disorder	<input type="checkbox"/>	
HEME	Easy Bleeding	HIV/AIDS	Hemophilia	<input type="checkbox"/>	



CEDAR VALLEY
BONE
HEALTH
INSTITUTE

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Are you a Diabetic? Yes No TREATMENT: Insulin Oral Meds Diet None

HAVE YOU EVER HAD?: Circle any conditions below: I do not have any of the conditions below

Asthma Sulfa allergy Heart attack (year)_____ Stroke, TIA's
Aspirin sensitivity Kidney failure High Blood Pressure Gerd
Stomach Ulcers Hepatitis Heart Failure Gluten Sensitivity
Bleeding Ulcers Liver Disease COPD Depression
Stomach ache taking anti-inflammatories (NSAIDS) Which NSAIDS? _____
Blood Clots that you had to take blood thinners to treat? Yes No When? _____

PAST SURGICAL HISTORY:

What operations have you had? When? None _____

Have you ever had a reaction to anesthesia? Yes No

PAST HOSPITALIZATIONS: (Not for Surgery) None _____

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?

Rheumatoid Arthritis _____ High Blood Pressure _____ Diabetes _____ None
Do any direct relatives have osteoporosis? Yes No Relationship: _____

SOCIAL HISTORY:

Marital Status: Married Single Divorced Widowed
Who lives with you? _____
If you live alone, what assistance do you have when needed? _____
Are you in "Assisted Living" or a Care Center? Yes No
Does your home have stairs? Yes No
Do you use a cane or walked for balance or support? Yes No
How far can you walk? _____
How far do you walk at least 5 times a week? _____
Is there anything else you want to tell us?

PLEASE SIGN: The information on these forms is accurate to the best of my knowledge.

X _____ Date _____

Office Use Only:

Review #1 by: _____ MD PA ARNP Date _____