

4006 Johnathan Street Waterloo, IA 50701 Phone: 319-233-2663

Fax: 319-287-8094

Patient Questionnaire

Name (print):		Da	ite of birth:		
Is there any chance that you	are pregnant?			Yes 🗆 No	
Have you had a barium X-ray	y or injection of dye	e in the past 2 weeks?		Yes 🗆 No	
	Call the office if y	ou answered yes to any	of the above		
1. Your Age : Gen	der: 🗆 Male	□ Female			
2. Your Ethnicity (check one): ☐ Caucasian (Wh	ite) 🛘 Black 🖺 Aborigina	l 🗌 Asian 🗎 Hispa	nic Other:	
Your country of birth if not	USA:				
3. When was your last bone		_ Never			
4. Your tallest height (high s	school or college):				
For women only (5-8)					
5. Are you still having mens	trual periods?			Yes 🗆 No	
6. Have you missed your pe	-	or more. except during i		Yes 🗆 No	
7. Have you had menopause			,	Yes 🗆 No	
8. Have you had a hysterect				Yes 🗆 No	
•	•	noved? If yes, at what a			
·	•	, , , , , , , , , , , , , , , , , , , ,			
9. Have you ever broken a b	1	T			
Broken Bone	Simple Fall?	Describe Injury		Age When Oc	curred
10. Has a parent fractured a	hip?			Yes 🗆 No	
11. Has a grandparent, siste	er, brother, aunt, o	r uncle fractured a hip?		Yes 🗆 No	
12. Do you smoke?				Yes 🗆 No 🗆	Never
13. Are you currently receiv	ing or have you n	revieusly received predn	isono nille (cortiso	2012	
Yes, currently Yes,		•	isone pins (cortisor	ne):	
If yes, for how long?	-		pills each day.		
14. Have you used steroid in			,		
Yes, currently Yes,	previously	No			
45. Da way have Dhawsate	مرسروا مثنات طنس ۵ اما	Cualan/a athan Autaines		Vaa 🗆 Na	
15. Do you have Rheumatoi	•		une disease?	Yes 🗌 No	
Asthma (CORD Read Cla	<u> </u>		Kidney Failure	Lastaca Cancit	
Asthma/COPD Blood Clo Had cancer?	ots GERD/OICEIS	Gluten Sensitivity		Lactose Sensit Yes No	ivity
Taken chemotherapy for car	ocor?			Yes 🗆 No	
Taken radiation for cancer?	icer:			Yes 🗆 No	
Taken medication to preven	t Organ transplant i	ejections	Ц	Yes 🗆 No	
16. List any chronic medical	conditions that yo	u have:			
17. Do you drink alcohol?	none	social 1	1-2 daily 3 o	or more daily.	

Medication			Ever?	Curre	ntly? If c	urrent	, how lon	g?	
Hormone repla	acement th	nerapy (Estroger	n)						
Raloxifene (Evi	sta)								
Γestosterone									
Calcitonin (Ma	lcalcin nas	al spray)							
Alendronate (Fosomax)								
Risendronate (Actonel)								
bandronate (E	Boniva) pill	S							
bandronate (E	Boniva) IV								
Zoledronic acid	d (Reclast)	IV							
Denosumab (P	rolia)								
Гегірагаtide (F	orteo)								
Abaloparatide	(Tymlos)								
Romosozumab	(Evenity)								
9. How many s	servings of	the following d	lo you eat/drir	nk per da	y (on avera	ge)?			
	Milk 8oz	Almond Milk 8	Boz Soy/Oat	Milk 8oz	Fortified O	8oz	Yogurt 40	z/6oz	Chees
Number of									
Servings									
1. Do you take 2. What other	vitamin D vitamin su	3? ☐ Y ☐ N If you	es, how much:						
1. Do you take 2. What other EVIEW OF SYS	vitamin D vitamin su TEMS:	 D3? □ Y □ N If y	es, how much:						
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