CEDAR VALLEY BONE HEALTH INSTITUTE

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Patient Questionnaire

Name (print):_____ **Date of birth**:_____

Is there any chance that you are pregnant? ☐ Yes ☐ No

Have you had a barium X-ray or injection of dye in the past 2 weeks? ☐ Yes ☐ No

Call the office if you answered yes to any of the above

1. Your Age: _____ Gender: ☐ Male ☐ Female

2. Your Ethnicity (check one): ☐ Caucasian (White) ☐ Black ☐ Aboriginal ☐ Asian ☐ Hispanic Other:_____

Your country of birth if not USA: _____

3. When was your last bone density test? _____ ☐ Never

4. Your tallest height (high school or college): _____

For women only (5-8)

5. Are you still having menstrual periods? ☐ Yes ☐ No

6. Have you missed your periods for 6 months or more, except during pregnancy? ☐ Yes ☐ No

7. Have you had menopause? If yes, at what age?_____ ☐ Yes ☐ No

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

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

9. Have you ever broken a bone?

Broken Bone	Simple Fall?	Describe Injury	Age When Occurred

10. Has a parent fractured a hip? ☐ Yes ☐ No

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

12. Do you smoke? ☐ Yes ☐ No ☐ Never

13. 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.

14. Have you used steroid inhalers?

Yes, currently_____ Yes, previously_____ No_____

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

HAVE YOU EVER HAD: Circle any conditions below: ☐ None

Asthma/COPD	Blood Clots	GERD/Ulcers	Gluten Sensitivity	Kidney Failure	Lactose Sensitivity

Had cancer? ☐ Yes ☐ No

Taken chemotherapy for cancer? ☐ Yes ☐ No

Taken radiation for cancer? ☐ Yes ☐ No

Taken medication to prevent organ transplant rejection? ☐ Yes ☐ No

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

17. Do you drink alcohol? _____ none _____ social _____ 1-2 daily _____ 3 or more daily.

18. Have you been treated with any of the following medications?

Medication	Ever?	Currently?	If current, how long?
Hormone replacement therapy (Estrogen)			
Raloxifene (Evista)			
Testosterone			
Calcitonin (Malcalcin nasal spray)			
Alendronate (Fosomax)			
Risendronate (Actonel)			
Ibandronate (Boniva) pills			
Ibandronate (Boniva) IV			
Zoledronic acid (Reclast) IV			
Denosumab (Prolia)			
Teriparatide (Forteo)			
Abaloparatide (Tymlos)			
Romosozumab (Evenity)			

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

	Milk 8oz	Almond Milk 8oz	Soy/Oat Milk 8oz	Fortified OJ 8oz	Yogurt 4oz/6oz	Cheese 1oz
Number of Servings						

20. Do you take calcium supplements? □ **Y** □ **N If yes what kind and how often**:_____

21. Do you take vitamin D3? □ **Y** □ **N If yes, how much:** _____

22. What other vitamin supplements do you take? _____

REVIEW OF SYSTEMS:

CIRCLE ANY CONDITION BELOW THAT YOU HAVE OR CHECK NONE

System	Conditions:			None	Describe
M/S	Rheumatoid Arthritis	Gout	Back		
	Osteoporosis	Fracture:			
GI	Heartburn	Ulcers	GERD		
Cardo/Vas	Chest Pain	Palpitations			
Resp	Chronic Chough	Shortness of Breath	Asthma		
SKIN	Frequent Rashes	Skin Ulcers	Psoriasis		

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

Do any family members have osteoporosis? □ Yes □ No Relationship:_____

SOCIAL HISTORY:

Do you use a cane, walker or wheelchair for balance or support? □ Yes □ No

How far do you walk at least 3-5 times a week? _____

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_____

Revised 2021