CEDAR VALLEY BONE HEALTH INSTITUTE

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Patient Questionnaire

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

1. Any new problems not addressed at your last visit?: ☐ **Yes** ☐ **No**

2. What calcium supplements do you take? ☐ **Citrate** ☐ **Carbonate** ☐ **None Amount** :_____

3. What strength vitamin D3 supplements do you take? _____

4. What other vitamin supplements do you take? _____

5. Are you on an Osteoporosis medication? _____

6. Are you having any problems with your Osteoporosis medication? ☐ **Yes** ☐ **No**

Describe the problem: _____

_____

7. Have you had lab work since your last visit? ☐ **Yes** ☐ **No**

When? _____

Where? _____

8. Do you have any questions that need to be addressed today? _____

_____

_____

9. Current weight: _____

10. Do you smoke? ☐ **Yes** ☐ **No** ☐ **Never**

Since your last Visit:

11. Been Hospitalized? ☐ **Yes** ☐ **No** When, Where, Why? _____

12. New Medications? ☐ **Yes** ☐ **No** Medication? _____

13. Medication stopped or changed? ☐ **Yes** ☐ **No** _____

PLEASE SIGN: The information on this form is accurate to the best of my knowledge.

X_____ Date_____

Office Use Only:

Review #1 by: _____MD PA ARNP Date_____

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