WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

Multidisciplinary Osteoporosis Program
76 Grenville Street, Level 4
Toronto, ON M5S 1B2
Phone (416) 323-2663 Fax (416) 323-6484

FOLLOW UP PATIENT QUESTIONNAIRE (To be completed by patient)

Date of Appointment: _____/_____/____ Name:_____
Y Y Y Y / M M / D D First Name Last Name

SOCIAL HISTORY

Accessibility challenges:
- ☐ hearing: _____
- ☐ visual: _____
- ☐ mobility:_____
- ☐ none

Living arrangements:
- ☐ with spouse or relatives
- ☐ nursing home
- ☐ retirement home
- ☐ alone
- ☐ other:_____

ALLERGIES

To medications: ☐ yes (please explain):_____ ☐ no
Other allergies: ☐ yes (please explain):_____ ☐ no

LIST YOUR MEDICATIONS

Medication (name, dose and how you take it)	Medication (name, dose and how you take it)
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

If you have taken an osteoporosis medication, have you ever experienced any **thigh**, **groin** or **hip pain**?
- ☐ yes (please explain):_____
- ☐ no

WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

Multidisciplinary Osteoporosis Program
FOLLOW UP PATIENT QUESTIONNAIRE

Date: _____/____/____
Y Y Y Y / M M / D D

HEALTH HISTORY

Please tell us about any changes to your health since your last appointment in this clinic:

Have you been *newly* diagnosed with cancer?
- ☐ yes (please explain and describe treatment):_____
- ☐ no

Have you been *newly* diagnosed with any other health condition, been hospitalized, or had surgery?
- ☐ yes (please explain):_____
- ☐ no

Are you taking, or have you taken any of these medications?

	now	before	when stopped
☐ steroids for at least 3 months example: prednisone	○	○	_____
☐ inhaled steroids every day for at least 1 year example: fluticasone/salmeterol (Advair®), or fluticasone (Flovent®)	○	○	_____

Do you have a *new* history of :
- ☐ balance problems ☐ falls ☐ dizziness or lightheadedness

Please explain:_____

How many times have you fallen to the ground in the last year?
- ☐ 0 ☐ 1 - 3 ☐ 4 – 6 ☐ more than 6

Have you broken any bones? how did it happen?
- ☐ yes……
  - ○ hip …….. _____
  - ○ wrist …….. _____
  - ○ spine …….. _____
  - ○ rib …….. _____
  - ○ other…….. _____
- ☐ no

Have you had severe back pain that needed bed rest?
- ☐ yes (please explain):_____
- ☐ no

Have you had dental surgery, example tooth extractions or dental implants?
- ☐ yes (please explain):_____
- ☐ no
- ☐ planned dental/oral surgery: _____

Do you have any oral health problems, example gum disease?
- ☐ yes (please explain): _____
- ☐ none

WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

Multidisciplinary Osteoporosis Program
FOLLOW UP PATIENT QUESTIONNAIRE

Date: _____/____/____
Y Y Y Y / M M / D D

LIFESTYLE / SELF MANAGEMENT

Are you a smoker? ☐ yes ☐ no ☐ used to smoke

Do you drink alcohol? ☐ yes……on average per week: _____ beer (bottle / can)
_____ wine (4 oz. glass) _____ liquor (1 oz. in a drink)
☐ no / rarely

How many servings of these foods do you usually eat each week?
_____ canned salmon (with bones, ½ can) _____ milk (1 cup) _____ cheese (1" cube)
_____ calcium fortified beverage (1 cup) _____ tofu (¾ cup) _____ yogurt (¾ cup)

Are you physically active? ☐ active…… ○ walking……. _____ hours/week
○ gym ……. _____ hours/week
○ other:…….. _____ hours/week
☐ not active

What are your most important health concerns? _____
_____

How confident are you in managing your bone health? Circle a number on the scale from 1 to 10:

	not confident									very confident
nutrition / healthy eating…….	1	2	3	4	5	6	7	8	9	10
activity / exercise……	1	2	3	4	5	6	7	8	9	10
preventing fractures……	1	2	3	4	5	6	7	8	9	10
preventing falls……	1	2	3	4	5	6	7	8	9	10
finding resources in community..	1	2	3	4	5	6	7	8	9	10

What is the most important concern you want to focus on regarding your bone health?_____
_____

WOMEN'S SECTION

Are you still menstruating? ☐ yes ☐ no…….at what age did your periods stop? _____ yrs

Why are you no longer menstruating?
☐ natural menopause ☐ chemotherapy
☐ hysterectomy……how many ovaries were removed?
○ none ○ one ○ two

Questionnaire completed by:_____ _____ Date: _____/____/____
Print name Signature Y Y Y Y / M M / D D

Relationship to patient:_____

Reviewed by:_____ Date: _____/____/____
Y Y Y Y / M M / D D