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

NEW 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

Age: _____ years

Ethnic Background: ☐ Caucasian (white) ☐ Black ☐ Asian
☐ other: _____

Preferred language: speak: _____ read/write: _____
Do you need a translator? ☐ yes ☐ no

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

Education completed: ☐ grade school ☐ high school ☐ college/university

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.

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HEALTH HISTORY

Have you ever been diagnosed by a doctor with any of these conditions? Please check the boxes that apply and circle your condition.

- ☐ Inflammatory arthritis (example: rheumatoid, psoriatic, ankylosing spondylitis)
- ☐ Malabsorption disorder (example: ulcerative colitis, Crohn's disease, Celiac disease)
- ☐ Kidney disease (example: kidney stones)
- ☐ Liver disease
- ☐ Lung disease (example: emphysema, asthma, COPD, chronic bronchitis)
- ☐ Organ transplant (example: kidney, liver, heart, lung, pancreas, bone marrow)
- ☐ Thyroid disease (example: overactive thyroid)
- ☐ Parathyroid disease (example: overactive parathyroid)
- ☐ Seizure disorder (example: epilepsy)
- ☐ Stomach problems (example: ulcer, hiatus hernia, acid reflux)
- ☐ Lupus
- ☐ Osteogenesis Imperfecta
- ☐ Paget's disease
- ☐ Eating disorder (example: anorexia, bulimia)
- ☐ Heart problems (example: heart attack, heart failure, abnormal heartbeat, arrhythmia)
- ☐ Other long standing medical problem(s):_____

Tell us about your cancer history:

- ☐ multiple myeloma
- ☐ breast cancer……
  - ○ chemotherapy/radiation_____
  - ○ surgery_____
  - ○ tamoxifen
  - ○ aromatase inhibitor; example: anastrozole (Arimidex®), letrozole (Femara®), exemestane (Aromasin®)
  - ○ other_____
- ☐ prostate cancer……
  - ○ surgery_____
  - ○ medication(s)_____
  - ○ other_____
- ☐ other cancer:_____
- ☐ none

Please list all operations you have had:

Operation	Year of operation
1.	
2.	
3.	
4.	
5.	

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Are you taking, or have you ever taken any medications for your bones?

	now	before	when stopped
☐ alendronate (Fosamax®)	○	○	_____
☐ risedronate (Actonel®)	○	○	_____
☐ etidronate (Didrocal®)	○	○	_____
☐ raloxifene (Evista®)	○	○	_____
☐ parathyroid hormone, teriparatide (Forteo®)	○	○	_____
☐ IV zoledronic acid (Aclasta®)	○	○	_____
☐ IV pamidronate	○	○	_____
☐ denosumab (Prolia®)	○	○	_____
☐ calcitonin (Miacalcin®)	○	○	_____
☐ other osteoporosis medication:_____	○	○	_____

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

Are you taking, or have you ever taken any of these hormones?

	now	before	when stopped
☐ hormone replacement therapy (example: estrogen, progestin)	○	○	_____
☐ medroxyprogesterone injections (Depo-Provera®) for more than 1 year	○	○	_____
☐ leuprolide (Lupron®)	○	○	_____

Are you taking, or have you ever taken any of these other 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®)	○	○	_____
☐ anti-seizure medication for at least 3 months example: phenytoin (Dilantin®), carbamezapine (**TEG**retol®) or **PHEN**obarbitol	○	○	_____

Do you have a 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

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Have you broken any bones?

- ☐ none
- ☐ yes……. ○ hip..…….. _____…… _____
  - ○ wrist …….. _____…… _____
  - ○ spine..…….. _____…… _____
  - ○ rib..…….. _____..... _____
  - ○ other..…….. _____..... _____

Do you have a family history of osteoporosis?

- ☐ yes…….. ○ mother……did she break her hip?.....○ yes ○ no
  - ○ father…….....did he break his hip?.....○ yes ○ no
  - ○ sisters / brothers
  - ○ grandparents
  - ○ other relative:_____
- ☐ no or unknown

Have you had severe back pain that needed bed rest?

- ☐ yes (please explain):_____
- ☐ no

Have you had dental surgery, example tooth extractions, dental implants, etc.:

- ☐ yes (please explain):_____
- ☐ no
- ☐ planned dental/oral surgery: _____

Do you have any oral health problems, example gum disease?

- ☐ yes (please explain):_____
- ☐ no

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 eat on average each week?

_____ milk (1 cup) _____ cheese (1" cube)
_____ tofu (3/4 cup) _____ yogurt (3/4 cup)
_____ calcium fortified beverage (1 cup)
_____ canned salmon (with bones, ½ can)

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

Have your periods ever stopped for more than 6 months (not including pregnancy)?
☐ yes (please explain) :_____
☐ no

Did you have your first period *after* the age of 14? ☐ yes, at age:_____ ☐ no
How many children have you given birth to? _____
If you breastfed your children, what is the *total* combined length of time you breastfed? _____

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