**QUESTIONNAIRE (To be completed by patient)**

**List your Medications and Supplements (or attach a list):**

<table>
<thead>
<tr>
<th>Medication (name, dose and how you take it)</th>
<th>Medication (name, dose and how you take it)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>6.</td>
</tr>
<tr>
<td>2.</td>
<td>7.</td>
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<tr>
<td>3.</td>
<td>8.</td>
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<td>4.</td>
<td>9.</td>
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<tr>
<td>5.</td>
<td>10.</td>
</tr>
</tbody>
</table>

**Medication Allergies**  □ No □ Yes (provide details):

**Check if you have taken any of the following bone medication(s). If yes, which years?**

- □ Alendronate (Fosamax®)
- □ Risedronate (Actonel®)
- □ Etidronate (Didrocal®)
- □ Raloxifene (Evista®)
- □ Teriparatide (Forteo®)
- □ IV Zoledronic Acid (Aclasta®)
- □ IV Pamidronate
- □ Denosumab (Prolia®)
- □ Calcitonin (Miacalcin®)
- □ Other:

**If you have taken an osteoporosis medication, have you ever experienced any thigh, groin or hip pain?**

- □ No □ Yes (provide details):

**Have you broken any bones?**

- □ No
- □ Yes

<table>
<thead>
<tr>
<th>Operation</th>
<th>Year</th>
<th>Operation</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrist</td>
<td></td>
<td>Wrist</td>
<td></td>
</tr>
<tr>
<td>Spine</td>
<td></td>
<td>Spine</td>
<td></td>
</tr>
<tr>
<td>Rib</td>
<td></td>
<td>Rib</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**Do you get regular dental care/checkups?** □ No □ Yes

**List recent or planned dental surgery (tooth extractions, dental implants, etc.):**

**List operations you have had:**

<table>
<thead>
<tr>
<th>Operation</th>
<th>Year</th>
<th>Operation</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>3.</td>
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<tr>
<td>2.</td>
<td></td>
<td>4.</td>
<td></td>
</tr>
</tbody>
</table>
HEALTH HISTORY:
Have you ever been diagnosed with any of these conditions? Please check boxes that apply and circle your condition.

☐ Inflammatory conditions (rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, lupus)
☐ Malabsorption disorder (ulcerative colitis, Crohn’s disease, Celiac disease)
☐ Kidney disease (Chronic kidney disease, dialysis, kidney stones)
☐ Liver disease
☐ Lung disease (emphysema, asthma, COPD, chronic bronchitis)
☐ Organ transplant (kidney, liver, heart, lung, pancreas, bone marrow)
☐ Thyroid disease (overactive thyroid)
☐ Parathyroid disease (overactive parathyroid)
☐ Seizure disorder (epilepsy)
☐ Stomach problems (ulcer, hiatus hernia, acid reflux)
☐ Eating disorder (anorexia, bulimia)
☐ Cancer ☐ Multiple myeloma ☐ Breast ☐ Prostate ☐ Other:__________________________
☐ Other long standing medical problem(s):_________________________________________

Do you currently smoke?  ☐ No  ☐ Yes  ☐ Ex-smoker

Do you drink more than 3 alcoholic beverages a day?  ☐ No  ☐ Yes
(1 beverage = 10oz beer = 4oz wine = 1oz hard liquor)

How many servings of these foods do you eat on average each week?

________ milk (1 cup) __________ cheese (1” cube)
________ calcium fortified beverage (1 cup) __________ yogurt (3/4 cup)

Has your mother or father ever broken their hip?  ☐ No  ☐ Yes

Have you had any falls in the past 12 months?  ☐ No  ☐ Yes

TAKING CARE of YOUR BONE HEALTH – HOW ARE YOU DOING?
How confident are you in self-managing (taking care of) your bone health? Please rate yourself on the following on a scale from 1 (you are not confident at all) to 10 (you are very confident):

Nutrition/Healthy Eating ________ Activity/Exercise ________ Knowing how to avoid falls and/or fractures________
(1….10) (1….10) (1….10)

Questionnaire completed by: _____________________________ Date: __/___/____
Print name ___________________________ Signature: ___________________________

If not completed by patient what is your relationship to the patient: ___________________________