WCHI
WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

The Centre for Osteoporosis & Bone Health
76 Grenville Street, 4th Floor; Toronto, ON M5S 1B2
Phone (416) 323-2663 Fax (416) 323-6484

QUESTIONNAIRE (To be completed by patient)

DATE: ___/___/_____
DD / MM / YYYY

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

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.

Medication Allergies ☐ No ☐ Yes (provide details):_____

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

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

		Age	How did it happen?
☐ Yes ⟹	○ Hip	_____	_____
	○ Wrist	_____	_____
	○ Spine	_____	_____
	○ Rib	_____	_____
	○ Other	_____	_____

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:

Operation	Year	Operation	Year
1.		3.	
2.		4.	

Please Turn Over

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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 _____ (1….10) Activity/Exercise _____ (1….10) Knowing how to avoid falls and/or fractures_____ (1….10)

Questionnaire completed by:_____ _____ Date :___/___/_____
Print name Signature DD / MM / YYYY

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