Bone Health Questionnaire

Name: ___________________________________        Date: ____________________________

1. How did you hear about this program? ____________________________

2. Have you had height loss or gotten shorter since your 20's?
   □ No        □ Yes – How much in your best estimate? ____________ inches

3. If female: Are you still having periods?
   □ No  Circle - naturally OR surgical hysterectomy with ovaries removed?    □ Yes

4. If male: have you ever been told you have low testosterone?
   □ No        □ Yes

5. Did you ever take hormone replacement therapy?
   □ No        □ Yes

6. Are you a Vegetarian or Vegan?
   □ No        □ Yes

7. Do you currently smoke, or did you?
   □ No        □ Yes

8. Do you drink alcohol?
   □ No        □ Yes

9. Have you had more than 2 falls in the past year?
   □ No        □ Yes

10. How active have you been in the last 12 months? (prior to injury)
    □ Not able to walk
    □ Not active (walking less than a mile a day)
    □ Somewhat active (walking some but less than 2 miles a day)
    □ Very active (walking 2 or more miles a day)

11. How many caffeinated beverages do you have a day (1 serving = 8 oz)
    □ No caffeinated beverages □ Less than 3 servings a day □ More than 3 servings a day

12. Did either of your parents have a hip fracture after the age of 50 or any family history of osteoporosis?
    □ No        □ Yes

13. Have you ever been diagnosed with any of the following diseases or disorders? (check all that apply)
Rheumatoid arthritis  □  Lupus  □  Seizure Disorder
Celiac disease or absorption disorder  □  Gastric Bypass  □  Hep B or C
COPD  □  GERD  □  HIV/AIDS
Hyperparathyroidism  □  Hypothyroidism  □  Paget’s Disease
Diabetes  □  Kidney stones

14. Current Fractures:
□ No  □ Yes - Location: _______________________________________________________
Date of fracture: _____________________________________________________________

15. Have you broken any other bones since you turned 50 or older besides your current broken bone?
□ No  □ Yes (please list all) – Where _______________________________________________

16. Have you had a Bone Density scan or DXA in the past 2 years?
□ No  □ Yes – Location: _______________________________________________________

17. Are you current or have you ever taken any of the following medications? How long?

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>How Long</th>
<th>Drug Name</th>
<th>How Long</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fosamax (alendronate)</td>
<td></td>
<td>Forteo (Teriparatide)</td>
<td></td>
</tr>
<tr>
<td>Didronel (etidronate)</td>
<td></td>
<td>Prolia (Denosumab)</td>
<td></td>
</tr>
<tr>
<td>Boniva (Ibandranate)</td>
<td></td>
<td>Anticonvulsant (Gabapentin, Lyrica, Lamictal)</td>
<td></td>
</tr>
<tr>
<td>Aredia (Pamidronate)</td>
<td></td>
<td>Anticoagulants (Heparin, warfarin)</td>
<td></td>
</tr>
<tr>
<td>Actonel (Risedronate)</td>
<td></td>
<td>Opioids (oxycodone/oxycontin)</td>
<td></td>
</tr>
<tr>
<td>Reclast (Zoledronate)</td>
<td></td>
<td>Oral steroids (prednisone)</td>
<td></td>
</tr>
<tr>
<td>Fortical (Calcitonin)</td>
<td></td>
<td>PPI’s (Omeprazole, Prilosec, Nexium)</td>
<td></td>
</tr>
<tr>
<td>Miacalcin (nose spray)</td>
<td></td>
<td>SSRI’s (Lexapro, Celexa, Sertalline)</td>
<td></td>
</tr>
<tr>
<td>Evista (Raloxifene)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

18. Have you ever had a high or low Calcium level?
□ No  □ Yes

19. Have you ever had a low Vitamin D level?
□ No  □ Yes

20. Are you taking either of the following nutritional supplements? If so, dose and how long?

Vitamin D - □ No  □ Yes
Calcium - □ No  □ Yes

21. Have you ever been treated for cancer with high beam radiation or had radioactive implants?
□ No  □