

Name	DOB	Date
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## BETTER BONE CLINIC HISTORY

*Please allow for ample time in order to thoroughly complete this paperwork. You will need to be at home in order to reference many of the details that are asked throughout. Failure to complete this will result in rescheduling.*

Preferred name		Age*	Sex*
Address			
Home phone		Cell	
Primary Insurance	Member ID	Group	
Secondary Insurance	Member ID	Group	
Name on insurance card	DOB	Relationship to you:	
Referring physician			
Race	Ethnicity	Preferred language	
Marital Status	Spouse/partner name		
With whom do you live?			

### HEALTH HISTORY

What was your tallest height? (late teens or young adult)	
What is your current height?*	
What is your current weight?*	
Are you right or left handed?	

### Past Fracture History\*

Have you broken any bones after age 40?

Type of fracture	Y/N	Date	Age	How did it happen?	Was it a fall from standing height?	Surgery or Cast
Left Hip						
Right Hip						
Vertebral Spine Which level(s)? _____						
Left Wrist						
Right Wrist						
Pelvic						
Other: _____						

### Fall History

I have fallen in the past year.	How many times? _____
I use or have been advised to use a cane or walker to get around safely.	
Sometimes I feel unsteady when I am walking.	
I steady myself by holding onto furniture when walking at home.	
I have area rugs in my home.	
I am worried about falling.	
I have pets in my home.	
I walk my dog on a leash.	
I need to push with my hands to stand up from a chair.	
I have some trouble stepping <b>up</b> on to a curb/stairs.	
I have some trouble stepping <b>down</b> from a curb/stairs.	
I often have to rush to the toilet.	
I have lost some feeling in my feet.	
I take medicine that sometimes makes me feel light-headed or more tired than usual.	

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<input type="checkbox"/>	I take medicine to help me sleep or improve my mood.
<input type="checkbox"/>	I take prescribed pain medication.
<input type="checkbox"/>	I often feel sad or depressed.

**Family History**

1.	Do you have a family history of osteoporosis or fractures (hip, spine, or wrist)?
2.	If so, what is their relationship to you?
3.	Has a parent or sibling had a fragility fracture (a fracture resulting from a fall from a standing height)?
4.	Has a parent had a hip fracture?*
5.	Do you have a family history of autoimmune disease?
6.	If so, which disease and what is their relationship to you?

**Bone Density Test (DXA scan) History**

Date	Physician who ordered	Facility where it was completed

**Medical History**

Major illnesses:

**Have you had any of the following medical conditions?**

<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	Blood clots in legs or lungs	<input type="checkbox"/>	Lupus—Systemic SLE
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Malabsorption/Inflammatory Bowel
<input type="checkbox"/>	Celiac disease	<input type="checkbox"/>	Paget’s Disease
<input type="checkbox"/>	Chronic Kidney Disease (CKD)	<input type="checkbox"/>	Parathyroid Gland Problems
<input type="checkbox"/>	Chronic pain	<input type="checkbox"/>	Peripheral Neuropathy
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Renal Failure/Dialysis
<input type="checkbox"/>	Diabetes Type I	<input type="checkbox"/>	Rheumatoid Arthritis*
<input type="checkbox"/>	Diabetes Type II	<input type="checkbox"/>	Seizure Disorder
<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	Stomach removal (Gastrectomy)
<input type="checkbox"/>	Gastric bypass or sleeve surgery	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Gastric reflux (acid reflux, heartburn, GERD)	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	Gluten sensitivity	<input type="checkbox"/>	Transplant
<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	Vitamin D deficiency
<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Other:

**CHECK IF YOU HAVE A HISTORY OF:**

<input type="checkbox"/>	Bleeding tendencies	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	Swollen lymph nodes	<input type="checkbox"/>	Frequent cough (once a day or more)
<input type="checkbox"/>	Sleeping problems	<input type="checkbox"/>	Coughing up phlegm or mucus daily
<input type="checkbox"/>	Urine leakage	<input type="checkbox"/>	Profuse sweating at night
<input type="checkbox"/>	Change in stool color	<input type="checkbox"/>	Frequent vomiting
<input type="checkbox"/>	Frequent urination at night	<input type="checkbox"/>	Balance problems
<input type="checkbox"/>	Problems with memory/concentration	<input type="checkbox"/>	Hard of Hearing
<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	Coordination problems
<input type="checkbox"/>	Shortness of breath at rest	<input type="checkbox"/>	Blurred or Double vision
<input type="checkbox"/>	Shortness of breath with little exertion	<input type="checkbox"/>	Joint pain/swelling (other than your spine)
<input type="checkbox"/>	Shortness of breath while lying flat	<input type="checkbox"/>	Muscle pain/spasm
<input type="checkbox"/>	Swelling of the feet, ankles and/or legs	<input type="checkbox"/>	Numbness/tingling of hand, arm, leg or foot

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Leg pain with prolonged walking	Weakness of leg or arm
Recent fractures	If you are female, any chance you are pregnant?
Rash	Sensitivity to chemicals
Excessively tired	Ringing in your ears
Bowel or bladder abnormalities	Frequent headache
Diarrhea	Dizziness
Constipation	Emotionally traumatic event
Pelvic pain	Anxiety attacks
Hyperventilating spells	Weight gain of _____ pounds in last 6 months
Females: painful menstrual periods	Weight loss of _____ pounds in last 6 months

### Cancer History

Have you had cancer? NO / YES [type: \_\_\_\_\_ year of diagnosis: \_\_\_\_\_ age at diagnosis: \_\_\_\_\_]  
 Who is your oncologist? \_\_\_\_\_  
 How was it treated?     Surgery                       Radiation             Chemotherapy  
 If breast cancer:        Tamoxifen (from \_\_\_\_\_ to \_\_\_\_\_)  
                                   Aromatase Inhibitor (from \_\_\_\_\_ to \_\_\_\_\_)

### Past Surgical History

Back or neck surgery	Specify:
Cardiac catheterization	
Cholecystectomy (gallbladder removal)	
C-section	
Exercise stress test	
Gastric bypass or sleeve	
Heart Surgery	
Hernia (hiatal, abdomen or groin)	
Implants or reconstruction	
Joint replacement	Specify:
Kyphoplasty	
Mastectomy	
Metal implants	
Pacemaker	
Other surgery:	

### Renal Failure

1. Do you have renal (kidney) failure?
2. What was the cause of your renal failure?
3. Have you ever had a kidney biopsy?
4. Have you ever been on or are you on peritoneal dialysis or hemodialysis?
5. Have you had a renal transplant?

### Bone Biopsy

1. Have you ever had a bone (marrow) biopsy?
2. If yes, where was it done?
3. When was it done?
4. Why was it done?

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Is there any information that is not already included in this form that you feel is important for us to know regarding your health? \_\_\_\_\_  
 \_\_\_\_\_

Past Osteoporosis Medications					
	Drug Name	Currently receiving or discontinued?	Start/End dates	Who prescribed?	Did you receive it at home or in an office?
Bisphosphonates	Actonel (Risedronate)				
	Boniva (Ibandronate)				
	Fosamax (Alendronate)				
	Reclast (Zoledronic Acid)				
Anabolics	Evenity (Romosozumab)				
	Forteo (Teriparatide)				
	Teriparatide				
	Tymlos (Abaloparatide)				
Anti-resorptives	Jubbonti (Denosumab-bbdz)				
	Prolia (Denosumab)				
	Stoboclo (Denosumab-bmwo)				
	Xgeva (Denosumab)				
SERM	Evista (Raloxifene)				

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Have you ever taken any of the following medications?	EXAMPLES	Y/N
Medication for seizures/epilepsy	Dilantin, Depakote, Neurontin, Tegretol, Lamictal	
Chemotherapy for cancer	Methotrexate, Arimidex, etc.	
Oral or injected steroids/cortisone for asthma/arthritis/inflammatory disorders	Medrol, Prednisone	
Thyroid medication	Synthroid (levothyroxine), PTU, Tapazole	
Hormone suppression for cancer or endometriosis	Lupron, Tamoxifen, Arimidex	
Gastric Reflux medication	Prilosec, Nexium, Dexilant, Protonix, Prevacid	
Narcotic pain medication	Hydrocodone, Oxycontin, Codeine	
Lithium	Eskolith, Lithobid	
Blood thinners	Heparin, Coumadin (Warfarin), Xarelto, Eliquis, Plavix	
Hormone Replacement	Estrogen, Testosterone	

**MEDICATIONS**

Drug name	Dose	How often do you take in a day?	How long have you been on this medication?

**Drug allergies**


**Diet & Supplements**

**Dietary Calcium**

Do you get significant amounts of calcium through your diet?	
Did you grow up drinking milk?	
Are you lactose intolerant?	
How many cups of milk do you drink per week?	
How many ounces of cheese do you eat per week?	
How many cups of calcium-fortified orange juice do you drink per week?	
How many cups of yogurt or kefir do you eat per week?	
How many cups of cottage cheese do you eat per week?	

**Calcium Supplements**

Type of Calcium pill	Brand name	Dose of calcium per pill	How many pills do you take per day?
Calcium Carbonate			
Calcium citrate			
Calcium lactate			
Calcium gluconate			
Algae/Plant based			

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Other: _____			
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<b>Multivitamin</b>			
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Brand name			
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How many tablets do you take per day?			
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<b>Vitamin D3</b>			
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Brand name	Tablet, gelcap, or drops?		
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_____ IU/ _____ mcg PER tablet/gelcap/drops			
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Is there any additional Vitamin D listed in your multivitamin?	_____ IU/ _____ mcg		
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Total Vitamin D3 per day _____ IU/ _____ mcg			
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<b>Vitamin K/K<sub>2</sub></b>			
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Brand name			
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How is it listed in the ingredients: K or K <sub>2</sub> ?			
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Is there any additional K or K <sub>2</sub> listed in your multivitamin?			
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<b>Magnesium</b>			
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What type of Magnesium do you take? (Please review labels on all supplement bottles. Choose all that apply.)

<input type="checkbox"/>	Magnesium Oxide	Dose: _____ mg
<input type="checkbox"/>	Magnesium Citrate	Dose: _____ mg
<input type="checkbox"/>	Magnesium Chloride	Dose: _____ mg
<input type="checkbox"/>	Magnesium Malate	Dose: _____ mg
<input type="checkbox"/>	Magnesium Sulfate	Dose: _____ mg
<input type="checkbox"/>	Magnesium Glycinate	Dose: _____ mg

<b>Collagen</b>			
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Brand name	Powder or capsules	Grams per serving	Do you take collagen daily?
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Type			
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Collagen			
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Multi-collagen			
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Marine Collagen			
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<b>Zinc</b>			
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Do you take Zinc alone or in your multivitamin?			
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Do you take zinc daily?	If so, how much?		
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Or do you only take it as needed for colds?			
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<b>Hormonal Factors</b>			
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IF YOU ARE A FEMALE PATIENT:

Who is your gynecologist?			
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When did you begin having menstrual periods? Age: _____ Year: _____			
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Do you have any children?			
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If so, what are their ages?			
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Did you ever skip your menstrual period for a long period of time?			
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Are you currently on or have you ever been on hormonal contraception? _____ If so, for how long?			
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When did you stop having periods (menopause)? Age: _____ Year: _____			
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<input type="checkbox"/> Natural menopause?
<input type="checkbox"/> Surgical menopause?
<input type="checkbox"/> Hysterectomy but kept ovaries
<input type="checkbox"/> Hysterectomy plus ovaries removed
Are you on hormone replacement therapy? _____ Estrogen _____ Progesterone
If <u>yes</u> , when did it begin?
<input type="checkbox"/> Shortly after menopause (months)?
<input type="checkbox"/> Later after menopause (____ months/years after menopause or surgery)
Are you still on hormone replacement therapy? YES/NO
If <u>no</u> , when did you stop? _____
How long were you on it? _____ year(s)

<b>IF YOU ARE A MALE PATIENT:</b>
1. Have you ever had a history of male infertility?
2. Have you ever been told that you have low testosterone?
3. Have you ever taken testosterone therapy?

<b>Corticosteroids*</b>
1. Do you currently take corticosteroid? (Prednisone, prednisolone, decadron, Medrol, or inhaled steroid?)
a. If yes, what is the name of the steroid you take?
b. What is the dose?
c. How long have you taken the steroid?
2. If you are not currently taking corticosteroids: Did you take them in the past?
a. If yes, what is the name of the steroid you take?
b. What is the dose?
c. How long did you take the steroid? [short term/long term/chronic/daily]
d. What was it prescribed for?

<b>Anabolic Steroids</b>
1. Do you currently take anabolic steroids such as testosterone (patches or injection), Decadurabolin?
a. If yes, what is the name of the steroid you take?
b. What is the dose?
c. How long have you taken the steroid?
2. If you are not currently taking anabolic steroids (testosterone, decadurabolin), did you take them in the past?
a. If yes, what is the name of the steroid you take?
b. What is the dose?
c. How long have you taken the steroid?

<b>Thyroid Disease</b>
1. Do you have thyroid problems?
2. If yes, have you had <b>hyper</b> thyroidism (high thyroid levels) or <b>hypo</b> thyroidism (low thyroid levels)?
3. Do you take thyroid replacement currently?
4. If yes, what is the name and dose of the pill that you take?
5. If you do not take thyroid replacement currently—did you take it in the past?

<b>Parathyroid Disease</b>
1. Have you had hyper <b>para</b> thyroidism (high parathyroid level)?
2. Have you ever had a high calcium level in your blood? If so, when? Why?
3. Have you ever had a parathyroidectomy?
4. If yes, when and where was the parathyroidectomy performed?

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**PERSONAL HABITS**

**Smoking History**

1. Have you smoked at least 100 cigarettes in your entire life?

*If you currently smoke\*:*

1. How many cigarettes or packs per day do you smoke?

2. For how many years have you smoked?

*If you smoked in the past:*

1. How long ago was the last cigarette smoked?

2. How many cigarettes or packs per day did you smoke?

3. For how many years did you smoke?

**Caffeine Intake**

1. Do you consume caffeinated beverages currently?

2. How many caffeinated beverages are consumed per day?

<i>Beverage</i>	<i>How many cups per day?</i>
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Caffeinated coffee	
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Caffeinated tea	
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Caffeinated soft drink	
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**Alcohol Intake**

1. Do you consume alcohol at present?

2. Did you consume alcohol in the past?

3. How many drinks per week are/were consumed?\*

<i>Beverage</i>	<i>Drinks per week</i>
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Wine (5 ounce glass is a drink)	
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Beer (12 ounce glass, can or bottle is a drink)	
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Hard liquor (1 ounce is a drink)	
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**Exercise**

1. Do you exercise on a regular basis?

2. If yes, what type of exercise?

3. For how many minutes do you exercise per week?

**Work History**

Working?	Current occupation:
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Retired?	Previous occupation:
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**Dental Intake**

1. Who is your dentist?

2. Do you have regular visits?

3. Do you have any upcoming procedures planned?

**Vaccination History**

1. Have you had a flu shot in the last 12 months?

2. If over 65 years old, have you had the pneumococcal vaccine?

**Pharmacies**

	Name	Address/Location	Phone number
Local retail pharmacy			
Insurance's Mail-in pharmacy			
Insurance's preferred specialty pharmacy (if known)			

Patient signature

Date