

Diagnostic Center For Women
7500 SW 87th Ave, Miami, FL 33173
305-740-5100

PATIENT HISTORY QUESTIONNAIRE

Name:		Today's Date:	
Patient ID:		Sex:	<input type="radio"/> F <input type="radio"/> M
Current Height: (in)		Date of Birth :	
Weight: (lb)		Referring Physician:	
Menopause Age:		Ethnicity:	

1. Have you had a previous hip or vertebral fracture? Yes No
2. Have you had any fractures during your adult life which did not result from significant trauma (e.g., auto accident)? Yes No
3. Did either of your parents ever have a hip fracture? Yes No
4. Do you smoke? Yes No
5. Have you ever taken Glucocorticoids? Yes No
6. Do you have rheumatoid arthritis? Yes No
7. Do you have secondary osteoporosis? Yes No
8. Do you drink 3 or more alcoholic drinks per day? Yes No
9. Are you being treated for osteoporosis? Yes No

10. Have you ever taken any of the following medications:
- | | |
|--------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Actonel (i.e. risedronate) | <input type="checkbox"/> Boniva (i.e. ibandronate) |
| <input type="checkbox"/> Evista (i.e. raloxifene) | <input type="checkbox"/> Forteo (i.e. parathyroid hormone) |
| <input type="checkbox"/> Fosamax (i.e. alendronate) | <input type="checkbox"/> HRT (i.e. estrogen/hormone therapy) |
| <input type="checkbox"/> Miacalcin (i.e. calcitonin) | <input type="checkbox"/> Protelos (i.e. strontium ranelate) |
| <input type="checkbox"/> Reclast (i.e. zoledronate) | <input type="checkbox"/> Prolia (i.e. denosumab) |
| <input type="checkbox"/> Vitamin D | <input type="checkbox"/> Calcium |
| <input type="checkbox"/> Other - Please specify: _____ | |

11. Do you have any of the following medical conditions:
- | | |
|--------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Anorexia or Bulimia | <input type="checkbox"/> Any Seizure Disorders |
| <input type="checkbox"/> Asthma or Emphysema | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> End stage renal disease | <input type="checkbox"/> Inflammatory bowel diseases |
| <input type="checkbox"/> Hyperparathyroidism | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Other - Please specify: _____ | |

12. What was your maximum height (inches)?
13. Do you perform weight bearing exercise regularly? Yes No
14. Do you regularly consume dairy products? Yes No
15. Do you drink caffeinated beverages? Yes No

- If female:
16. At what age did your period start?
17. Are you premenopausal? Yes No
18. How many full term pregnancies have you had?
19. Have you ever missed your period for more than 6 months in a row (not including pregnancy or menopause)? Yes No