

Osteoporosis Questionnaire

Name		DOB_		Date		
Sex Race	Family Background	d / Ethnicit	y (ie: German) _.			
Peak Adult Height	Office use or	<u>nly:</u> Cu	rrent Height _	Weigh	t	
Osteoporosis History:						
Have you ever had a bone density	test before? Yes _	No _				
If yes, when and where did you ha	ve it?					
Did your previous bone density sca	an diagnose you wi	ith osteope	enia or osteopo	rosis? Yes	No	
Are you currently taking any osteo	oorosis medication	s?Yes	_ No If yes	s, list name		
Have you discontinued any osteop you discontinued it.			-		medication and why	
Do you have a family history of ost	eoporosis? Yes	_No F	Relationship:			
Has either of your parents ever fra	ctured a hip? Yes	No	_ If yes, how di	d it occur?		
Bone Fracture History: Have you ever fractured or broken a bone after the age of 40 yrs? Yes No						
Bone Broken	How did it Happen?					
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Menstrual History:	having periods for	more that	n 1 vear\? Ves	No. If ve	s what are?	
Are you postmenopausal (stopped having periods for more than 1 year)? Yes No If yes, what age? Are you currently having symptoms of menopause? Yes No If yes, what was the age of onset?						
Have you had a hysterectomy? Ye						
Have you had both ovaries remove		_				
, ,		, .		-		
Medication History: Are you or ha	ave you ever taken	any of the	following med	ications?		
Medication				ny Years?	If in past, when	
					stopped?	
Antiseizure drugs (Dilantin, Phenol	<i>'</i>					
Medication to prevent return of cancer						
Hormone replacement therapy						
Hormone suppressing agents (Lupron, Depo Provera)						
Steroids (prednisone, orisone, delt	asone)					
Technician comments:						

Name	D.O.B	Date
Medical History:		
•	ag any of the following health	h problems? Please check or answer below.
Back pain (specify) low, mid, upper	Cancer (type)	·
Back surgeries (type)	Chemo/Radiation	
•		
Autoimmune disorder	Kidney disease	Intestinal disorder (specify)
Thyroid disease	Vitamin D deficiency	
Hyperparathyroidism	Rheumatoid Arthritis	Bariatric surgery
Eating disorder	Diabetes	
Frequent falls		
Exercise History:		
How often do you exercise?		
What type of exercise do you usually	y do?	
Smoking:		
Do you smoke? Yes: No:	How many years?	If you quit, when did you quit?
Calcium and Vitamin D Assessme How many servings of calcium rich f Do you take a calcium supplement? If yes, how many milligrams per day Do you take vitamin D? Yes: If yes, how many IU of vitamin D per	ent: foods do you average per da Yes: No: ? No:	y?
Medication:		

WELCOME TO GREAT LAKES CENTER OF RHEUMATOLOGY WEST

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Great Lakes Center of Rheumatology West to release any medical or incidental information that may be necessary for either medical care or in processing applicants for financial benefits.

ASSIGNMENT OF INSURANCE BENEFITS

- I hereby direct payment of surgical/medical benefits to the Great Lakes Center of Rheumatology
 West for services rendered by him/her in person or under his/her supervision
- I understand that I am financially responsible for any balance not covered by my insurance.
- I certify that the information given by me on the age below is current and correct.
- I request that payment of authorized benefits made be made on my behalf
- I have reviewed and agree with the Great Lakes Center of Rheumatology West privacy practices.

BONE DENSITY FOLLOW UP VISIT

Bone density follow up counseling appointments are billed as a separate office call. The fee for these appointments is **not** included in the bone density scan charge.

RECORDS RELEASE

There is a records fee for copying and mailing reports to patients. You may get a copy for free at your Bone density follow up appointment. Your primary care physician or ordering doctor will be sent a copy of the report.

Patient Name (print)	DOB	
Patient signature	Date	
Parent/Guardian	Date	