Cedar Valley Bone Health Institute
United Medical Park
1753 West Ridgeway Avenue, Suite 103A
Waterloo, Iowa
319-233-BONE (2663)
www.cvbonehealth.com

Patient Questionnaire

Name (print):____ Date:_________________

Is there any chance that you are pregnant? Yes No
Have you had a barium X-ray in the last 2 weeks? Yes No
Have you had a nuclear medicine scan or injection of an X-ray dye in the last week? Yes No
Have you had hyperparathyroidism or a high calcium level in your blood? Yes No

If you have answered any of the above, speak to our receptionist right away.

1. Your Age:______ Sex: Male Female

2. Your Ethnicity (check one):
___Caucasian (White) ___Black ___Aboriginal ___Asian ___Hispanic ___Other:______________
Your country of birth:_____________________

3. Have you ever had a bone density test? Yes No
If yes, when and where?_________________________________

4. What is your current weight? _________lbs.
Have you had a recent weight change? Yes No
If yes, tell us about it:____

5. Your tallest height (late teens or young adult):_______________

6. Have you ever broken a bone?

Broken Bone	Simple Fall?	If not a simple fall, please describe the circumstances	Age when this occurred

7. Has a parent or sibling had a broken hip from a simple fall or bump? Yes No

8. Has a parent or sibling had any other type of broken bone from a simple fall or bump? Yes No

9. How many times have you fallen in the last year?__________

10. Have you ever had surgery of the spine, hips, legs or arms? Yes No
If yes, describe what type of surgery you had and which side was affected.
____
____

11. Are you currently receiving or have you previously received prednisone pills (cortisone)?
Yes, currently_____ Yes, previously_____ No_____
If yes, for how long?_________ What is your dose?______mg or _____pills each day

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12. List any chronic medical conditions that you have:

____
____
____
____
____

13. Are you currently receiving or have you previously received any of the following medications?

	No	**Yes**	**For how long?**
Medication for seizures or epilepsy			
Chemotherapy for cancer			
Medication for prostate cancer			
Medication to prevent organ transplant rejection			
Medication for thyroid			
Diuretics Medication			
Heparin Medication			
Methotrexate Medication			
Medication for Sleep aids			

14. Have you been treated with any of the following medications?

Medication	**Ever?**	**Currently?**	**If current, how long?**
Hormone replacement therapy (Estrogen)			
Tamoxifen			
Raloxifene (Evista)			
Testosterone			
Etidronate (Didronel/Didrocal)			
Alendronate (Fosamax)			
Risedronate (Actonel)			
Intravenous pamidronate (Aredia)			
Clodronate (Bonefos, Ostac)			
Calcitonin (Miacalcin nasal spray)			
PTH (Forteo)			
Zoledronic acid (Zometa)			
Sodium fluoride (Fluotic)			

15. How many servings of the following do you eat/drink per day (on average)?

	Milk (full cup)	**Orange Juice fortified with calcium (full cup)**	**Yogurt (small container or ½ cup)**	**Cheese**
Number of Servings				

16. Do you take any calcium supplements (including TUMS)? Yes No

17. Do you take any vitamin D supplements (including multivitamins and halibut liver oil)? Yes No

18. Do you smoke? Yes No

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For women only…

19. Are you still having menstrual periods? Yes No

20. Before menopause, have you ever missed your periods for 6 months or more, besides during pregnancy? Yes No

21. Have you had your menopause? Yes No
    If yes, at what age?__________

22. Have you had a hysterectomy? Yes No
    If yes, at what age?__________
    Have you had both of your ovaries removed? Yes No
    If yes, at what age?__________

REVIEW OF SYSTEMS:

CIRCLE ANY CONDITION BELOW THAT YOU HAVE OR CHECK NONE

System	***Conditions:***			***None***	***Describe***
M/S	Rheumatoid Arthritis	Gout	Back Pain	☐	
	Osteoporosis	Fracture: Which bone?___________			
GI	Heartburn	Ulcers	Nausea	☐	
	Vomiting	Blood in stool			
ENDO	Frequent Thirst	Frequent Urination	Always Hot or Cold	☐	
CONST	Weight Loss	Frequent Fever	Loss of appetite	☐	
EYE	Blurred Vision	Double Vision	Vision Loss	☐	
ENT	Hearing Loss	Hoarseness	Trouble swallowing	☐	
C-VASC	Chest Pain	Palpitations		☐	
RESP	Chronic Cough	Shortness of Breath		☐	
GU	Painful Urination	Blood in Urine	Kidney Problems	☐	
SKIN	Frequent Rashes	Skin Ulcers	Psoriasis	☐	
NEURO	Headaches	Dizziness	Seizures	☐	
PSYCH	Drug/Alcohol Problem	Depression	Sleep Disorder	☐	
HEME	Easy Bleeding	HIV/AIDS	Hemophilia	☐	

ALLERGY:

Do you have Allergies to medications? ☐Yes ☐No If yes, LIST ALL ALLERGIES TO MEDICINE BELOW

PAST MEDICAL HISTORY:

What MEDICATIONS do you take? ☐None Please list below with dosage.

Are you a Diabetic? ☐Yes ☐No TREATMENT: ☐Insulin ☐Oral Meds ☐Diet ☐None

HAVE YOU EVER HAD?: Circle any conditions below: ☐I do not have any of the conditions below

Asthma	Sulfa allergy	Heart attack (year)_______	Stroke, TIA's
Aspirin sensitivity	Kidney failure	High Blood Pressure	Cancer(location)______
Stomach Ulcers	Hepatitis	Heart Failure	Radiation
Bleeding Ulcers	Liver Disease	COPD	Depression

Stomach ache taking anti-inflammatories (NSAIDS) Which NSAIDS?________________________

Blood Clots that you had to take blood thinners to treat? ☐Yes ☐No When?________________

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PAST SURGICAL HISTORY:
What operations have you had? When? ☐None____
____
Have you ever had a reaction to anesthesia? ☐Yes ☐No

PAST HOSPITALIZATIONS: (Not for Surgery) ☐None____

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?
☐Hemophilia_____☐High Blood Pressure______ ☐Diabetes_____ ☐Rheumatoid Arthritis_____ ☐None
Do any direct relatives have the same condition you are being seen for today? ☐Yes ☐No Relationship:_________

SOCIAL HISTORY:
Do you use tobacco? ☐Yes ☐No Packs per day___ Alcohol Use? ☐None ☐Social ☐Daily ☐Frequently
Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed How many people live with you?__________
Occupation:___________________ ☐Student Employer:_______________________________
Do you like your job? ☐Yes ☐No Do you plan to be working 6 months from now? ☐Yes ☐No

PLEASE SIGN: The information on these forms is accurate to the best of my knowledge.

X____

Office Use Only:
Complete: ____ Date__/__/____ Review #1 by: _________________MD PA ARNP Date__/__/____
Review #2 by: _________________MD PA ARNP Date__/__/____