

**Dr. David Hanley Osteoporosis Centre
Health History Form**

When complete, please email this form to DHOC@ahs.ca.

Alternatively, it can be mailed or faxed to the address or number at the bottom of this page.

Patient Information

Patient Name: _____	Phone Number: _____
Contact Person: _____	Contact Role/Relation: _____
Contact's Phone Number: _____	Family Doctor: _____
Drug Insurance Provider: _____	Pharmacy: _____
Referral Reason: _____	
What is your Current/Former Occupation? _____	

Osteoporosis Education

Have you attended the "Osteoporosis and Bone Health" Class?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, when did you attend the class? _____		
If no, have you viewed our videos at www.osteoporosiscalgary.com ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any Comments about the classes/videos? _____		

History

Please check off all of the following diagnosis you have currently or have been given in the past and note any details you feel we should be aware of.

<input type="checkbox"/> Blood Clots (Legs, or Lungs)	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Cancer (specify)	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Parathyroid Disease (Hyperparathyroidism)
<input type="checkbox"/> Dementia	<input type="checkbox"/> Rheumatoid/Inflammatory Arthritis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Gastric Reflux (GERD)	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Swallowing problem
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Transplant
<input type="checkbox"/> IBS (Irritable Bowel Syndrome)	<input type="checkbox"/> Thyroid Disease (hyper, hypo)
<input type="checkbox"/> IBD (Inflammatory Bowel Disease, Crohn's, Ulcerative Colitis)	<input type="checkbox"/> Other:
Additional notes:	

Please answer the questions below to the best of your ability.

Do you partake in any physical activity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, specify type, frequency and duration:
Had you had any falls in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, what amount?
Do you use a mobility or walking aid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, what type of aid?
Do you have back pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, where?
Have you become shorter?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how many inches and what has been your tallest recorded height?
Have you had any Fractures after the age of 40?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, indicate which bones, the year and how it happened:
Have you had any surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, specify the year and procedure:
Do you have any major dental surgery pending?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please describe:
Have any of your family members broken a hip?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, who and what age were they?
What do you think your current weight is (estimate if you do not have a scale)?			
Have you lost weight recently without trying?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how much weight have you lost? <input type="checkbox"/> 2-11 lbs (1-5kg) <input type="checkbox"/> 12-22 lbs (6-10 kg) <input type="checkbox"/> 23-33 lbs (11-15 kg) <input type="checkbox"/> >33 lb (>15 kg) <input type="checkbox"/> Unsure
Have you been eating poorly because of decreased appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please describe:
Do you ever have difficulty making ends meet at the end of the month?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please describe:
Females only:			
What was your approximate age when you had your first period?			
What was your approximate age at Menopause (last period)?			
Have you had Hormone Replacement Therapy (HRT)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please describe:
Males only:			
What was your approximate age of onset of Puberty?			

Please mark off whether you have used any of the substances below and note any details to the best of your ability.

Tobacco	(Current Use):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, what type, how much per day and length of use?
	(Past Use):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Caffeine	(Current Use):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how many cups per day?
	(Past Use):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Alcohol	(Current Use):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how many drinks per week?
	(Past Use):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Have you ever taken any of the medications below?

Name	Start Date & Stop Date (if applicable)	Reason for Taking and/or Stopping
<input type="checkbox"/> Etidronate (Didrocal)		
<input type="checkbox"/> Alendronate (Fosamax)		
<input type="checkbox"/> Risedronate (Actonel)		
<input type="checkbox"/> Raloxifene (Evista)		
<input type="checkbox"/> Pamidronate (Aredia)		
<input type="checkbox"/> Zoledronate (Aclasta, Zometa)		
<input type="checkbox"/> Teriparatide, PTH (Forteo)		
<input type="checkbox"/> Denosumab (Prolia)		
<input type="checkbox"/> Romosozumab (Evenity)		
<input type="checkbox"/> Prednisone (for over 3 months)		
<input type="checkbox"/> Anticonvulsants (for seizures)		
<input type="checkbox"/> Heparin (injectable blood thinner)		
<input type="checkbox"/> Chemotherapy		
<input type="checkbox"/> Diuretics (water pill)		

Are you currently taking any of the supplements below?

Name	Dose & Frequency of Supplements (if known)	Amount in Diet (if known)	Start Date
<input type="checkbox"/> Calcium (mg/day), please specify: <input type="checkbox"/> Carbonate <input type="checkbox"/> Citrate <input type="checkbox"/> Other			
<input type="checkbox"/> Vitamin D (IU/day)			

Patient Label

Please attach a medication list from your pharmacy or blister pack and/or list all other current medications including over the counter medications, supplements, herbs, vitamins and minerals you are taking.

Name	Start Date	Reason for Taking

Do you have any food or drug allergies or intolerances? Please attach an allergy list if you need more room.

Name	Allergy or Intolerance	Reaction/Explanation
	<input type="checkbox"/> Allergy <input type="checkbox"/> Intolerance	
	<input type="checkbox"/> Allergy <input type="checkbox"/> Intolerance	
	<input type="checkbox"/> Allergy <input type="checkbox"/> Intolerance	
	<input type="checkbox"/> Allergy <input type="checkbox"/> Intolerance	
	<input type="checkbox"/> Allergy <input type="checkbox"/> Intolerance	
	<input type="checkbox"/> Allergy <input type="checkbox"/> Intolerance	

For Office Use Only	
Date: _____	
Height: _____ cm	Blood Pressure: _____ mm/Hg
Weight: _____ kg	Pulse: _____
BMI: _____	

3-Day Food and Activity Journal

Please see the other side for instructions about how to use this food journal.

Meal	Day 1: _____	Day 2: _____	Day 3: _____
Breakfast (First Meal)			
Snack			
Lunch (Second Meal)			
Snack			
Dinner (Third Meal)			
Snack			
Activity			

How to fill in this journal

- Write down everything you eat and drink. You may want to record **one weekday (or workday) and one Saturday or Sunday (or day off)**.
- Include:
 - How much food you ate. See the suggestions below to estimate portion sizes. If the food comes in a package, just write down the package size. Example: 175 mL container of yogurt.
 - How the food is cooked (for example: fried, baked, boiled, barbecued)
 - Anything you add to food, during or after cooking. Example: cream, sugar, oil, butter, jam, syrup, ketchup or other sauces, dressings or condiments.
 - Details about restaurant foods, fast foods, or packaged foods (for example: McDonald's Big Mac[®] or KFC[®] chicken).
- Measure the food you eat for a day or two to help you understand how much you eat and drink. Use measuring cups and spoons.
- Write down all your **activities** for the day. Include planned activities (going for a walk or swim) and activities of daily life (housework or grocery shopping). Comments may include where you ate, your mood, or stress level.
- Use more paper if you need to or photocopy the other side of this handout.
- Read over your journals to see what is working well and what you may want to change.
- Keep on tracking. Use this tool to help you meet your goals, or to make new goals.

To estimate portion sizes, use the guidelines below:

This amount of food:	...is about the same size as:
2½ oz (75g) of meat	a hockey puck
1½ oz (50 g) of cheese	2 white erasers
1 cup (250 mL)	a baseball or fist
½ cup (125 mL)	a hockey puck
1 medium piece of fruit	a tennis ball
2 Tbsp (30 mL)	1 golf ball
¼ cup (60 mL)	2 golf balls
1 tsp (5 mL) – use for butter, margarine, mayonnaise	a thumb tip or one die

Example of how to fill in your food journal:

Meal	Day 1: Thursday	Day 2: Saturday
Breakfast (First Meal)	1 cup Bran Flakes [®] with 1 tsp sugar and ½ cup 1% milk 1 cup coffee black 1 slice whole wheat toast with 2 tsp soft margarine	1 egg fried in 1 tsp butter with 3 strips of bacon 2 slices whole wheat toast with 2 tsp soft margarine 2 cups tea (chamomile)
Snack	1 carrot muffin - Tim Hortons [®] 1 medium black coffee - Tim Hortons [®]	1 medium apple
Activity	Stressful day at work	30 minute walk