OSTEOPOROSIS CENTRE

Health History Form

2014

Patient Name: ________________________ Alberta Health Care Number: __ __ __ __ __ - __ __ __ __

Family Doctor: _______________________ Referral Reason: ___________________________________

Drug Insurance Provider: ____

Have you Attended the "*Osteoporosis and Bone Health*" or Viewed Online Presentation? ☐ Yes ☐ No

What is your Current/ Former Occupation: ____

Please answer the questions below to the best of your ability

Do you have back pain? ☐ Yes ☐ No *(If Yes, Where?)* _________________________

Have you Become Shorter? ☐ Yes ☐ No *(If Yes, How Many Inches?)* ______________

What has been your tallest recorded Height? _______

Have you had any Fractures *after the age of 40*? ☐ Yes ☐ No *(If Yes, Indicate which bones, Year & how below)*

____

Medical History

Please check all that apply below

☐ Rheumatoid Arthritis	☐ Hyperthyroidism	☐ High Blood Pressure
☐ Primary Hyperparathyroidism	☐ Hypothyroidism	☐ Kidney Stones
☐ Cancer	☐ Blood Clots (Legs Or Lungs)	☐ Heart Disease
☐ Celiac Disease	☐ Crohn's Disease	☐ Ulcerative Colitis
☐ Transplant	☐ Seizure Disorder	☐ Other (*Please Specify Below*)

Please answer the questions below to the best of your ability

Male: *On Set of Puberty?*	☐ Early	☐ Average	☐ Late
Female	Age at Menopause?	Age of onset of Menses?	Hormone Replacement Therapy?

Have you had any surgery? ☐ Yes ☐ No (If Yes, Specify) ________________________________

Any allergies to food or drugs? ☐ Yes ☐ No (If Yes, Specify) __________________________

Any family members break a hip? ☐ Yes ☐ No (If Yes, who?) ___________________________

Any family members loose height / Stooped? ☐ Yes ☐ No (If Yes, Who?) ________________

Smoking (Current Use):	☐ Yes	☐ No	*If Yes, Packs Per Day / Number of Years?*
(Past Use):	☐ Yes	☐ No	*If Yes, Packs Per Day / Number of Years?*
Caffeine (Current Use):	☐ Yes	☐ No	*If Yes, How Many Cups/ Day?*
(Past Use):	☐ Yes	☐ No	*If Yes, How Many Cups/ Day?*
Alcohol (Current Use):	☐ Yes	☐ No	*I Yes, How Many Drinks / Week?*
(Past Use):	☐ Yes	☐ No	*I Yes, How Many Drinks / Week?*

Alberta Health Services

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Calcium (mg/day): In your diet _______________ Supplement (s) _______________ Total = ___________________

Vitamin D (IU/day): ☐ Yes ☐ No (If Yes, what amount?) ____

Physical Activity): ☐ Yes ☐ No (If Yes, Specify?) ____

Any falls in the past year? ☐ Yes ☐ No (If Yes, what amount?) __________________________________

Walking Aid? ☐ Yes ☐ No (If Yes, what type of aid?) ____

Medication Questions

Please fill all that apply below

Name	Start Date	Stop Date	Duration of Use	Reason for Stopping
☐ **Etidronate *(Didrocal)***				
☐ **Alendronate *(Fosamax)***				
☐ **Risedronate *(Actonel)***				
☐ **Raloxifene *(Evista)***				
☐ **Calcitonin *(Miacalcin)***				
☐ **Pamidronate *(Aredia)***				
☐ **Zolendronate *(Aclasta, Zometa)***				
☐ **Teriparatide, PTH *(Forteo)***				
☐ **Denosumab *(Prolia)***				

Have you ever taken any of the following medications below? ☐ Yes ☐ No

☐ **Prednisone** *(For Over 3 Months)*	☐ **Anticonvulsants**	☐ **Heparin**	☐ **Chemotherapy**	☐ **Diuretics**

List all current medications, Supplements, herbs, vitamins and minerals you are taking

(Or Attach a Separate Sheet)

Name	Dose & Frequency	Start Date	Reason for Taking