Fracture Liaison Clinic
Pre-Visit Questionnaire (In-Take Form)

Name: ___________________________ Date: ___________________________

1. How did you learn about this program?
   □ Primary care physician; please list physician’s name: ___________________________
   □ Other: ___________________________

2. Have you experienced height loss after age 29? □ Yes □ No
   ▪ If so, in your best estimate, how many inches have you lost? ___________________________

3. If you are female, are you still menstruating? □ Not Applicable □ Yes □ No
   ▪ Have you had your ovaries removed via surgical hysterectomy? □ Yes □ No
   ▪ If so, at what age was your surgery? ___________________________
   ▪ If you did not have your ovaries removed via surgical hysterectomy and you have completed
     menopause, at what age was your last period? ___________________________

4. If you are male, are you aware if you have low testosterone?
   □ Not Applicable □ Yes □ No

5. Have you ever taken hormone replacement therapy? □ Yes □ No

6. Are you a: □ Vegetarian □ Vegan □ Neither

7. Do you currently smoke?
   □ Yes □ No
   ▪ Have you ever smoked? □ Yes □ No

8. Do you drink alcohol?
   □ Yes □ No
   ▪ If yes, how many drinks do you have per week? __________

9. Have you fallen more than twice in the past year? □ Yes □ No

10. How active have you been in the last 12 months prior to your injury?
    □ Not able to walk
    □ Not active (walking less than a mile a day)
    □ Somewhat active (walking some, but less than 2 miles per day)
    □ Very active (walking 2 or more miles per day)
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11. How many caffeinated beverages do you drink in one day (1 serving = 8 oz)
   □ No caffeinated beverages
   □ Less than 3 servings a day
   □ More than 3 servings a day

12. Did either of your parents have a hip fracture after the age of 50 or do you have any family history of osteoporosis?
   □ Yes □ No

13. Have you ever been diagnosed with any of the following diseases or disorders? (Check all that apply).
   □ Rheumatoid Arthritis
   □ Lupus
   □ Celiac Disease or Absorption Disorder
   □ Gastric Bypass
   □ COPD
   □ GERD
   □ Hyperparathyroidism
   □ Hypothyroidism
   □ Diabetes
   □ Kidney Stones
   □ Seizure Disorder
   □ HIV/AIDS
   □ Hepatitis B or C
   □ Paget’s Disease

14. Do you currently have a fracture?
   □ Yes □ No
   ▪ If so, what bone is fractured? ___________ On what date did the injury occur? ___________

15. If you currently have a fractured bone, have you broken any other bones since turning age 50?
   □ Yes □ No
   ▪ If yes, please list all: ______________________________________________________________

16. Have you had a bone density scan or DEXA scan in the past 2 years?
   □ Yes □ No
   ▪ If yes, where and when: ____________________________________________________________
      ___________________________________________________________
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17. Are you currently or have you ever taken any of the following medications? If yes, please indicate the duration for each.
   □ Fosamax (Alendronate) ____________________________________________
   □ Didronel (Etidronate) ____________________________________________
   □ Boniva (Ibandronate) ____________________________________________
   □ Aredia (Pamidronate) ____________________________________________
   □ Actonel (Risedronate) ____________________________________________
   □ Reclast (Zoledronate) ____________________________________________
   □ Fortical (Calcitonin) ____________________________________________
   □ Miacalin (nasal spray) __________________________________________
   □ Evista (Raloxifene) ____________________________________________
   □ Forteo (Teriparatide) ____________________________________________
   □ Prolia (Denosumab) ____________________________________________
   □ Anticonvulsants (Gabapentin, Lyrica or Lamictal) ___________________
   □ Anticoagulants (Heparin, Warfarin) ________________________________
   □ Opioids (Oxycodone/Oxycontin) __________________________________
   □ Oral Steroids (Prednisone) ______________________________________
   □ PPI’s (Omeprazole, Prilosec or Nexium) ____________________________
   □ SSRI’s (Lexapro, Celexa or Sertaline) ______________________________

18. Have you ever had high or low calcium levels? □ Yes □ No
19. Have you ever had low vitamin D levels? □ Yes □ No
20. Are you taking any nutritional supplements (if so, please list the dose and duration):
    Calcium □ Yes □ No
    If yes, what dose and for how long? ___________________________________
    Vitamin D □ Yes □ No
    If yes, what dose and for how long? ___________________________________
21. Have you ever been treated for cancer with high beam radiation or had radioactive implants?
    □ Yes □ No If yes, what type? _______________________________________