Holland Hospital
BONE HEALTH
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# Osteoporosis Review of Systems

Name: _____ Date of Birth: _____ Date: _____

Have you experienced any of the following symptoms in the past **6 months**? Please check the box.

| | |
|---|---|
| Muscle / joint pain or weakness? | ☐ Yes ☐ No |
| Limits to your mobility or ability to do everyday tasks? | ☐ Yes ☐ No |
| Problems with your balance? | ☐ Yes ☐ No |
| Have you fallen? | ☐ Yes ☐ No |
| Problems with your memory? | ☐ Yes ☐ No |
| Do you typically use a cane or walker to get around? | ☐ Yes ☐ No |
| Serious skin infection or new rashes? | ☐ Yes ☐ No |
| Other types of infection? | ☐ Yes ☐ No |
| Have you **ever** had a kidney stone? | ☐ Yes ☐ No |
| Have you **ever** had a bariatric surgery for weight loss? | ☐ Yes ☐ No |
| Chronic diarrhea, constipation, heartburn, or other gastrointestinal complaints? | ☐ Yes ☐ No |

| | |
|---|---|
| Have you had a dental exam in the past year? | ☐ Yes ☐ No |
| Any current or recent dental concerns (such as extractions or implants)? | ☐ Yes ☐ No |
| Have you had an eye exam in the past year? | ☐ Yes ☐ No |
| Any vision concerns? _____ | ☐ Yes ☐ No |
| Have you had any other significant health problems in the last 6-12 months? | ☐ Yes ☐ No |

_____

Any concerns with current bone health treatments? _____ ☐ Yes ☐ No

_____

Laura Norder, FNP-C