BONE HEALTH
844 Washington Ave | Entrance B, Suite 1200 | Holland MI 49423
P (616) 393-5336 | **F** (616) 392-2889 | **W** hollandhospital.org

Dear New Patient,

Welcome to our practice! We are pleased that you chose Holland Hospital Bone Health for your health care needs. The following information is provided to ensure a smooth transition.

Please complete the new patient forms and bring them with you to your first appointment. This will help speed up the check-in process. These forms are available on our website: www.hollandhospital.org/bonehealth under the Medical Forms link.

We ask that you arrive 10 minutes prior to your appointment so that we are able to have your chart ready by your appointment time. Your New Patient appointment is scheduled for:

Date: _______ Time: __________ Provider: _________________ Location: _______________

If you have insurance coverage, please bring your **current** insurance cards and a valid photo identification card with you at the time of your appointment.

If for any reason you are unable to attend this appointment, please contact us at least 24 hours in advance. If you are not able to make your new patient appointment and you do not contact our office, we will not reschedule your appointment.

Should you have questions, please call us at (616) 393-5336.
We look forward to meeting you soon.

Warm regards,

Our Bone Health providers and staff

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Medical History Questionnaire

Name: ______________________________ Date of Birth: ___________________

Risk Factors

A. Steroid Use

1. Have you ever taken oral steroids? (Prednisone, Methylprednisolone) No Yes
2. If "Yes" – Why were you on steroids? _________________________________
3. If "Yes" – How long were you taking steroids? _________________________
4. If "Yes" – What was the dose? _______________________________________

B. Smoking

1. Have you **ever** been a smoker? No Yes
2. If "Yes" – How long did you smoke? ___________ Years ________
3. If "Yes" - How many packs per day did you typically smoke? _____ Packs
4. Are you currently a smoker? No Yes

C. Alcohol Use

1. Have you ever had more than 2 drinks of alcohol most days for an extended period of time? (1 drink = 12 oz of beer or 5 oz of wine, 1.5 oz of liquor) No Yes
2. If "Yes" – How long did you drink in this pattern? Months ______ Years_____
3. Do you currently drink in excess of 2 drinks per day? No Yes

D. Pain Medication Use

1. Have you ever taken narcotic pain medication **most days** for 3 or more months? No Yes

E. Fall Risk

1. Have you ever fallen in the last year? No Yes
2. Have you had any 'almost fell' events? No Yes

F. Fracture History

1. Have you had a bone fracture since age 50? No Yes
   Date: ________
2. Which bone fractured? ________________________
3. Any history of broken bones at a younger age? No Yes

G. Diet

1. Do you have food allergies? No Yes
   If "Yes" – Which foods? ____
2. Do you avoid any foods? No Yes
   If "Yes" – Which foods? ____
3. Are you lactose intolerant? No Yes
4. If "Yes" – When did you first notice this? ___________________
5. Did you drink milk and eat dairy products such as cheese and ice cream when you were growing up? No Yes

H. On the list of foods below, please write the number of servings you had of each of these foods during the past week. (If you drink a glass of milk every day then your servings for milk will be "7")

Milk 1 cup	Cream Soup 1 cup	Pudding ½ cup
Milkshake 8 oz.	Ice Cream 1 scoop	English Muffin
Cheese Pizza 1 slice	Salmon (canned with bones) 3 oz	Pancake
Soymilk 1 cup	Cheese 1 oz	Baked Beans 1 cup
Yogurt 1 cup	Waffle (1)	Almonds ¼ cup
Lasagna 1 serving	Cereal fortified with calcium 1 cup	Egg (1)
Orange (1)	Orange Juice with Calcium 1 cup	Broccoli 1 cup
Tomatoes 1 cup	Sardines (canned with bones) 3 oz	Cottage Cheese ½ cup

I. Supplements – Please bring in your supplements to your appointment.

1. Do you take any calcium pills? No Yes Milligrams of each pill? ________
2. Does your calcium contain Vitamin D? No Yes Amount in each pill? ________
3. How often do you take your calcium pills
   Twice a day Once a day 1-3 times a week 4-6 times a week Occasionally
4. How long have you been on this dose of calcium? ______________
5. Do you take a Vitamin D pill? No Yes
6. How often do you take your Vitamin D pill?
   Twice a day Once a day 1-3 times a week 4-6 times a week Occasionally
7. How long have you been on this does of Vitamin D? ___________________
8. If you take any other supplements such as a multivitamin that contain calcium or Vitamin D please write the amounts you take each day: Calcium _________ mg. Vitamin D ______iu.

J. Exercise

1. Do you do regular weight-bearing exercises (walking, running, weightlifting)? No Yes
2. If "Yes" – How many days a week do you participate in this exercise? _____ Days
3. If "Yes" - How many minutes a day do you participate in this exercise? _____ Minutes
4. If "No" – What is your greatest barrier to regular exercise? ________________________
5. What is your occupation (if retired, what did you do during your working years?
   ____
6. What would you say your activity level during your middle years 30-50 years old was in general?
   Very Low Activity Job Related Only Occasional Purposeful Exercise
   Moderate Purposeful Exercise Very Active Athletic

K. Hormone History

For Women

1. How old were you when you had your last menstrual period? ____________
2. Did you take the hormone replacement Cestrogen / progesterone? No Yes
3. If "Yes" – For how long? __________________

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For Men

1. Have you ever been diagnosed as having low testosterone levels? No Yes

L. Pertinent Family History

1. Have you had a parent, grandparent, or sibling that has broken a bone due to a fall from a standing height? No Yes
2. If "Yes" – Who? _______________ Which bone? ____________ Age at time of fracture? __________
3. Has any member of your immediate family (parents, maternal and paternal grandparents, siblings, or children) suffered from the following:

Condition:	Relationship to You:
Osteoporosis	____________________
Dowager's or Widow Hump	____________________
None of the Above	____________________

M. Osteoporosis History

1. Have you been diagnosed with osteoporosis? No Yes
2. When and how did you first become aware of a problem with your bones? _________________

Personal Risk Factors

1. What do you feel is (are) your major risk factor(s) for developing osteoporosis?

____

____

Treatment

1. Have you ever taken medication for osteoporosis?

Actonel (risedronate) Yes Start Date __________ Stop Date _________
Reason for stopping ____

Fosamax (alendronate) Yes Start Date __________ Stop Date _________
Reason for stopping ____

Boniva (ibandronate) Yes Start Date __________ Stop Date _________
Reason for stopping ____

Reclast (zoledronic acid) Yes Start Date __________ Stop Date _________
Reason for stopping ____

Calcitonin Nasal Spray Yes Start Date __________ Stop Date _________
Reason for stopping ____

Forteo (teraparatide) Yes Start Date __________ Stop Date _________
Reason for stopping ____

Prolia Yes Start Date __________ Stop Date _________
Reason for stopping ____

Evista (raloxifene) Yes Start Date __________ Stop Date _________
Reason for stopping ____