

BONE HEALTH

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

Welcome!

You have been scheduled for an appointment with Holland Hospital's Bone Health Services.

Below are some frequently asked questions. It is our hope that the answers provided will assist in getting the most out of your visit with us.

What is the purpose of this visit?

If you have been referred by your primary care provider and/or orthopedic surgeon to our office, it is because of concerns about the strength of your bones. There may be concerns because you already experienced a fracture or because your health care provider feels you are at an increased risk for fracturing.

Then goal of Holland Hospital's Bone Health Services is to prevent future fractures. We are sure you share in this goal! We will work with you to:

- 1. Identify risk factors for the two underlying causes of fractures: bone loss and falls.**
- 2. Modify or change the factors that are increasing your fracture risk.**

For example: We can help you determine if you are getting the right amount of calcium and vitamin D needed for healthy bones.

- 3. Choose a holistic treatment plan to improve your overall bone health.**

This plan may include starting or changing medications but goes well beyond prescribing medications.

What can I expect at my Osteoporosis Consultation?

A typical first visit will last 45 minutes. You will be seeing one of our nurse practitioners who specializes in bone health. Your visit will include:

1. A review of factors related to fracture risk including medications, diet, hormonal status, activity levels and other relevant behaviors.
2. A brief physical exam including evaluation of balance, strength, and risk for falls.
3. The possibility of additional laboratory testing, x-rays or bone mineral testing based on the findings of the visit and review of past records.

Patient education is a cornerstone of our services, so time is set aside to respond to your questions and concerns.

What can I do to make the visit more productive?

- Complete the questionnaires and bring them to your first visit. These forms can be found on our website at: www.hollandhospital.org/bonehealth. You can bring your completed form to your appointment or email them to us at: bonehealth@hollandhospital.org.
- Bring the actual bottles of any multi-vitamins, calcium, and vitamin D you are currently taking.
- Bring a written list of your questions and concerns as they relate to your bone health.

We look forward to working with you to improve your bone health and reduce your risk of future fractures.

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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?
Date: _____ | No | Yes |
| 2. Which bone fractured? _____ | | |
| 3. Any history of broken bones at a younger age? | No | Yes |

G. Diet

- | | | |
|-----------------------------------------------------------------------------------------------------|----|-----|
| 1. Do you have food allergies?
If "Yes" – Which foods? _____ | No | Yes |
| 2. Do you avoid any foods?
If "Yes" – Which foods? _____ | No | Yes |
| 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 |

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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 (teraparotide) | 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 _____ | | | |