

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: <u>www.hollandhospital.org/bonehealth</u>. 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 Yes No 1. Have you **ever** been a smoker? 2. If "Yes" – How long did you smoke? ______ Years _____ 3. If "Yes" - How many packs per day did you typically smoke? Packs No Yes 4. Are you currently a smoker? 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) Yes 2. If "Yes" – How long did you drink in this pattern? Months _____ Years___ No Yes 3. Do you currently drink in excess of 2 drinks per day? 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? Yes No 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? 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



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Н.		the list of foods be	•			_	•			during the	
	past week. (If you drink a glass of Milk 1 cup Milkshake 8 oz. Cheese Pizza 1 slice Soymilk 1 cup Yogurt 1 cup Lasagna 1 serving Orange (1) Tomatoes 1 cup			Cream Soup 1 cup Ice Cream 1 scoop Salmon (canned with bones) 3 oz Cheese 1 oz Waffle (1) Cereal fortified with calcium 1 cup Orange Juice with Calcium 1 cup Sardines (canned with bones) 3 oz				Pudding ½ cup English Muffin Pancake Baked Beans 1 cup Almonds ¼ cup Egg (1) Broccoli 1 cup Cottage Cheese ½ cup			
l.	Supplements – Please bring in your supplements to your appointment.										
	1. 2. 3.	, ,	Vitamin D? No				ams of each pill? It in each pill?				
	4. 5. 6. 7. 8.	Twice a day How long have y Do you take a Vi How often do yo Twice a day How long have y If you take any of	Once a d you been on tamin D pill ou take your Once a d you been on other supple	ay this dose ? Vitamin D lay this does ments suc	1-3 times of calcium pill? 1-3 times of Vitaminch as a mul	?a week D?tivitamin	4-6 times a	week - cium or '	Vitamin	Yes sionally	
J.	1. 2. 3. 4.	write the amour ercise Do you do regul If "Yes" – How m If "Yes" - How m If "No" – What is What is your occ	ar weight-be nany days a nany minute: s your great	earing exe week do y s a day do est barrier	rcises (wal rou particip you partic r to regular	king, runr pate in thi ipate in th	ning, weightliftin s exercise? nis exercise? ?	g)? Days Minu	No	Yes	
	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.	For '1. 2.	mone History Women How old were yo Did you take the If "Yes" – For ho	hormone re	· ·			·	_	No	Yes	



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For Men

	1	. Have you ever been diagr	nosed as	having low testost	erone 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 fr height?								
	2.	If "Yes" – Who?		Which bone?	Age at time of fract	ure?			
	3.	Has any member of your in children) suffered from the Condition: Osteoporosis Dowager's or Widow Hum None of the Above	e followi	- · · · · · · · · · · · · · · · · · · ·		arents,	siblings, o		
M.	1.	teoporosis History Have you been diagnosed When and how did you fire		•	lem with your bones?	No	Yes		
	Personal Risk Factors 1. What do you feel is (are) your major risk factor(s) for developing osteoporosis?								
	1.	Treatment Have you ever taken media Actonel (risedronate) Reason for stopping	Yes	Start Date	Stop Date				
		Fosamax (alendronate) Reason for stopping	Yes	Start Date	Stop Date				
		Boniva (ibandronate) Reason for stopping	Yes	Start Date	Stop Date				
		Reclast (zoledronic acid) Reason for stopping	Yes	Start Date	Stop Date				
		Calcitonin Nasal Spray Reason for stopping	Yes	Start Date	Stop Date				
		Forteo (teraparatide) Reason for stopping	Yes	Start Date	Stop Date				
		Prolia Reason for stopping	Yes	Start Date	Stop Date				
		Evista (raloxifene)	Yes	Start Date	Stop Date				

Reason for stopping _____