Follow-Up Questionnaire – Bone Health

Acct #:____________ **Date:**____________

CORE Provider:________________

For office use only

PATIENT INFORMATION

Patient Name: ____________________ DOB: __________ Age: _____

E-Mail: ____________________

PRESENT MEDICAL INFORMATION

Have you seen any other physician for osteoporosis or bone health? ☐No ☐Yes

Are you taking medications for osteoporosis or bone health? ☐No ☐Yes, please list below

Name of Medication	Dose (include strength and number of pills/injections per day/week/month)	Name of Medication	Dose (include strength and number of pills/injections per day/week/month)
1.		2.	

Are you taking nutritional supplements for osteoporosis or bone health? ☐Calcium _____ mg/day ☐Vitamin D _____ iu/day

☐Other, please list: ____________________

Since your last visit, have you:

Been prescribed any new medications? ☐No ☐Yes

Name of Medication	Dose (include strength and number of pills/injections per day/week/month)	Name of Medication	Dose (include strength and number of pills/injections per day/week/month)
1.		2.	

Broken any bones? ☐No ☐Yes

If yes, which bone and how did you break? ____________________

Experienced a fall? ☐No ☐Yes, how many: __________

If yes, what are you doing to prevent falls? ____________________

SOCIAL HISTORY

Exercise: ☐No ☐Yes What types of exercise? __________ How often and how long? __________

Tobacco: ☐No ☐Yes ☐Quit How many packs per day? __________ How many years? __________

Alcohol: ☐No ☐Yes ☐Quit How much do you drink daily? __________

Do you currently or have you ever abused alcohol ☐No ☐Yes

Illicit Drugs: Are you currently using any illicit substances? ☐No ☐Yes

Type: ☐Marijuana ☐Other: __________

Are there any questions you would like the provider to address for you at this visit? ____________________

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name: ____________________

Patient Signature: ____________________ Date: __________

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Reviewed By: ____________________ Date: __________

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