

Bone Health History:

Name: _____

Height: _____ ft. _____ inches

Weight: _____ lbs

- Date of last bone density scan _____
 - Result (Please circle) **normal osteopenia osteoporosis**
- Have you ever broken a bone? **No Yes** (If Yes, please complete table)

Bone broken	Please describe the circumstances	Age when this Occurred

- Have you taken steroids (Prednisone) for longer than 3 months? **Yes No**
- Has your mother or father fractured a hip? **Yes No**
- Family history of osteoporosis/bone disease? _____
- Have you used any of the following medications? (Please circle)
 - Dilantin**
 - Depo-Provera**
 - medicine for acid reflux (GERD)**
 - post-menopausal hormones (HRT)**

- Do you consume dairy products like milk, yogurt or cheese daily? **Yes No**
(please circle) **1-2 servings daily 3-4 servings daily 5 or more servings daily**
- Do you take calcium supplements? **No Yes** _____ mg per day
- Do you take vitamin D supplements? **No Yes** _____ units per day
- Do you exercise regularly (Regular exercise being 20-30 minutes of weight-bearing exercise 2-3 times a week i.e. walking, aerobics, bicycling.) **Yes No**
- Do you smoke cigarettes? **Yes No**
- Do you drink alcoholic beverages? _____ **servings per day**
- Have you been prescribed any of the following medications? (please circle)
 - Fosamax Actonel Boniva Reclast Calcitonin Evista Forteo**