Moreland OB-GYN Associates, S.C.

PATIENT QUESTIONNAIRE

NAME:_____DATE OF BIRTH:_____
PRIMARY MD:_____TODAY'S DATE:_____

Do you want a copy of this report sent to your primary MD?_____

1. Is there a chance you may be pregnant? Yes___ No__

2. Have you had a barium x-ray in the last 2 weeks? Yes_____No__

3. Have you had a nuclear medicine scan or injection of an x-ray dye in the last week? Yes_____ No____

4. Ethnicity: Caucasian (white)_____ Black_____ Asian_____ Hispanic_____Other__

5. Have you ever had a Bone Density Test? Yes_____ No____
If yes, where was it done?_____

6. Your tallest height (late teens or young adult)_____

7. Have you ever broken a bone? Yes__ No____
If yes, which bone did you break?_____ How did you break it?_____
At what age did you break it?_____

8. Do you have a family history of osteoporosis? Yes____ No____

9. Has a parent or sibling had a broken hip from a simple fall or bump?
Yes___ No____

10. Has a parent or sibling had any other type of broken bone from a simple fall or bump?
Yes___ No____

11. Are you currently receiving or have you previously received Prednisone or Cortisone? Yes currently_____ Yes previously_____ For how long?_____What is/was your dose?_____

12. List any chronic medical conditions that you have:_____
_____

13. Are you currently receiving or have you previously received any of the following medications?

	No	Yes	For how long?
Medications for seizures or epilepsy			
Chemotherapy for cancer			
Medication to prevent organ transplant rejection			

14. Have you been treated with any of the following medications?

	Ever?	Currently?	If currently, for how long?
Hormone replacement therapy (Estrogen)			
Tamoxifen			
Evista (Raloxifene)			
Armidex			
Testosterone			
Fosamax (Alendronate)			
Actonel (Risedronate)			
Boniva (Ibandronate Sodium)			
Forteo (PTH)			
Reclast (Zoledronic Acid)			

15. How many days a week do you exercise?_____ How long do you exercise each time?__ _____ What kind of exercise do you do?_____

16. How many servings of the following do you eat or drink per day on average?

Serving size	**Milk 1cup**	**Calcium enriched orange juice 1 cup**	**Yogurt ½ cup**	**Cheese 1 oz.**	**Other calcium rich foods 1 cup**
Number of servings					

17. Do you take Calcium supplements (including Tums) Yes___ No___
How many mg?_____

18. Do you take a Multivitamin? Yes_____ No____

19. Do you take a Vitamin D supplement? Yes_____ No_____
How many IU?_____

20. Do you smoke? Yes_____ No____

21. How much caffeine do you drink each day?_____

22. How much alcohol do you drink each day?_____

23. Are you still having periods? Yes_____ No_____

24. Have you had your menopause? Yes_____No_____ If yes, how old were you?_____

25. Have you had a hysterectomy? Yes_____No_____ If yes, how old were you?_____

26. Have you had both of your ovaries removed? Yes_____ No____