Yale Medicine

Welcome to the Yale Bone Center

Please take a moment to fill out the following questionnaire prior to your first visit with us.

NAME

First: ______________________ Last: ______________________

Ethnicity: ______________________
(This is needed to analyze your bone density and fracture risk)

Date of Birth: ______________________ Age: ________ Sex: ☐ Female ☐ Male

ADDRESS

Street: ______________________ Apt./Unit: ________

City: ______________________ State: ________ Zip: ________

PHONE

Home: ______________________ Best Time to Call: ______________________

Cell: ______________________ Best Time to Call: ______________________

REFERRING PROVIDER

Who referred you to us today? ______________________

REFERRING PROVIDER'S ADDRESS

Street: ______________________ Apt./Unit: ________

City: ______________________ State: ________ Zip: ________

Yale Medicine

Yale Bone Center Health Survey

What is the reason for your visit? ______________________________

How long have you had this diagnosis or problem? ______________________________

Do you have osteopenia or osteoporosis? ☐ Yes ☐ No

Have you ever had a bone density scan (DXA) before? ☐ Yes ☐ No

If yes: When and where? ______________________________

Why were you referred for it?

☐ Routine screening

☐ Follow-up testing

☐ Other reason: ______________________________

How many servings of dairy products do you eat every day?

Milk (1 serving = 8 ounce glass) __________ servings per day

Yogurt (1 serving = 8 ounces) __________ servings per day

Cheese (1 serving = 1 ounce) __________ servings per day

Cottage cheese (1 serving = 8 ounces) __________ servings per day

Are you lactose intolerant? ☐ Yes ☐ No

Do you take any calcium or vitamin D supplements? ☐ Yes ☐ No

If yes: How much calcium do you take each day? __________

What kind of calcium? __________

How much vitamin D do you take each day? __________

Do you take a multivitamin? ☐ Yes ☐ No

If yes: How much calcium is in it? __________

How much vitamin D is in it? __________

Do you take any prescription medications? ☐ Yes ☐ No

If yes: Please list them below (You may attach a list of medications if necessary)

Name of medication	Dose	Frequency (how many times per day)

For accessibility assistance, please contact Yale Medicine CARE Center at 1-877-YALEMDS.

Do you have any allergies to medications? ☐ Yes ☐ No

If yes: Please list and describe your reactions to them: ______________________________

____

Have you broken (fractured) any bones after age 21? ☐ Yes ☐ No

If yes: Which bone? (indicate L or R side)	How old were you?	How did you break it?
______________	______	______________
______________	______	______________
______________	______	______________
______________	______	______________

Have you had a hip replacement? ☐ Yes ☐ No

Did your father or mother break his/her hip after the age of 50? ☐ Yes ☐ No

Have you ever you smoked? ☐ Yes ☐ No

If yes: How much and for how many years: ______________________________

Do you smoke now? ☐ Yes ☐ No

Do you drink any alcohol? ☐ Yes ☐ No

If yes: What kind of drinks and how many glasses per week? ______________________________

Do you have rheumatoid arthritis? (This is an inflammatory arthritis, not "old age" arthritis) ☐ Yes ☐ No

Have you lost height as an adult (are you shorter)? ☐ Yes ☐ No

If yes: How many inches? ______________

Have you had a fall in the last 12 months? ☐ Yes ☐ No

Does anyone in your family have a history of osteoporosis? ☐ Yes ☐ No

Does anyone in your family have any other bone disease? ☐ Yes ☐ No

If yes: What type and who has it? ______________________________

Does anyone in your family have any calcium problems or disorders? ☐ Yes ☐ No

If yes: What type and who has it? ______________________________

Has anyone in your family had kidney stones? ☐ Yes ☐ No

If yes: Who? ______________________________

Medications

Have you ever taken steroids (ex: prednisone or decadron)? ☐ Yes ☐ No

If yes: Are you taking steroids now? ☐ Yes ☐ No

Which steroid? ____________________

Dose: __________ Start Date: __________ Stop Date: __________

Reason for taking steroid: ____________________

Have you ever taken any of the following medications for bone loss? ☐ Yes ☐ No

If yes: Please circle: Fosamax (alendronate)

Actonel (risedronate)

Boniva (ibandronate)

Reclast (zoledronic acid)

Pamidronate

Prolia (denosumab)

Forteo (Teriparatide)

Tymlos (abaloparatide)

Evista (raloxifene)

If yes: Are you taking any of those medications now? ☐ Yes ☐ No

How long did you or have you taken it? ____________________

If you stopped, when did you stop? ____________________

Have you ever taken seizure medications? ☐ Yes ☐ No

If yes: Are you taking them now? ☐ Yes ☐ No

Which seizure medications? ____________________

How long have you taken them? ____________________

Have you ever taken thyroid medications? ☐ Yes ☐ No

If yes: Are you taking them now? ☐ Yes ☐ No

Which thyroid medications? ____________________

How long have you taken them? ____________________

Why do you take them (diagnosis)? ____________________

Have you ever taken Lasix (furosemide)? ☐ Yes ☐ No

If yes: Are you taking it now? ☐ Yes ☐ No

Have you ever taken a blood thinner? ☐ Yes ☐ No

If yes: Are you taking it now? ☐ Yes ☐ No

Which one? ____________________

How long have you taken it? ____________________

Illnesses and Surgeries

Do you have osteoarthritis (this is arthritis of aging)? ☐ Yes ☐ No

Have you had an operation to remove any part of your stomach or intestine? ☐ Yes ☐ No
If yes: Which part did they remove? ____________________ When? ____________

Have you had cancer? ☐ Yes ☐ No
If yes: Which kind? ______________________________
Did you receive radiation therapy? ☐ Yes ☐ No
Did you receive chemotherapy? ☐ Yes ☐ No
If yes: What kind? ____________

Have you had an organ transplant? ☐ Yes ☐ No
If yes: Which organ? ____________

Do you have scoliosis of the spine? ☐ Yes ☐ No

Do you have diabetes? ☐ Type 1 ☐ Type 2 ☐ No

Do you have liver disease? ☐ Yes ☐ No

Do you have Crohn's disease? ☐ Yes ☐ No

Do you have Ulcerative colitis? ☐ Yes ☐ No

Do you have Cushing's syndrome? ☐ Yes ☐ No

Do you have Celiac disease? ☐ Yes ☐ No

Have you ever had an overactive thyroid? ☐ Yes ☐ No

Have you ever had an overactive PARAthyroid? ☐ Yes ☐ No
If yes: Did you have surgery for it? ☐ Yes ☐ No
When? ____________

Are you currently on dialysis for kidney failure? ☐ Yes ☐ No

Have you ever had any kidney stones? ☐ Yes ☐ No
If yes: When? ____________

Have you ever had a calcium disorder or problem? ☐ Yes ☐ No

Do you have any back pain? ☐ Yes ☐ No

Do you have any other medical problems? ☐ Yes ☐ No

If yes: Please list them below

Do you have any dental problems? ☐ Yes ☐ No

Have you had any recent dental procedures (Ex: Tooth extraction, root canal) or do you have any dental work planned for the future? ☐ Yes ☐ No

If yes: When? ______

Have you ever had any surgeries? ☐ Yes ☐ No

If yes: Please list them below with their approximate dates

For Women Only

At what age did you have your first period (menstruation)? ________________

Has there ever been a time in your life lasting more than 6 months when you had irregular periods or no periods at all (don't count pregnancies)? ☐ Yes ☐ No

If yes: When did this happen? ________________

Have you gone through menopause ("change of life")? ☐ Yes ☐ No

If yes: At what age? ________________

Are you taking any estrogen ("female hormones") NOW? ☐ Yes ☐ No

If yes: What kind? ________________

In the past did you take estrogen ("female hormones")? ☐ Yes ☐ No

Have you had your uterus removed? ☐ Yes ☐ No

If yes: When? ________________

Have you had one or both ovaries removed? ☐ One ☐ Both ☐ None

If yes: When?________________

For Men Only

Have you ever had infection or damage to your testicles? ☐ Yes ☐ No

If yes: What kind? ____

Have you ever been told you have low testosterone ("male hormone") level? ☐ Yes ☐ No

Have you ever been treated for prostate cancer? ☐ Yes ☐ No

If yes: What type of treatment have you received? ________________________________

Physical Activity

Please tell us how much time you spent doing the following activities during a typical week in the last month.

Activity

Activity		
Walking quickly (for more than 10 minutes)	______	hours per week
Exercising (calisthenics or aerobics)	______	hours per week
Cycling (on a regular bicycle or a stationary bicycle)	______	hours per week
Jogging (for more than 10 minutes)	______	hours per week
Dancing (modern or fast): ballroom, salsa, line dancing, etc.	______	hours per week
Racquet sports like tennis	______	hours per week
Weight lifting	______	hours per week
Yoga or Pilates	______	hours per week
Gym workout	______	hours per week
Other	______	hours per week

If you take any calcium, vitamin D, or multivitamins, please make sure to bring these bottles with you to your first visit.

Thank you for taking the time to fill out this questionnaire. Please bring this questionnaire with you to your first visit. I look forward to seeing you soon.

Sincerely,

Grace S. Lee, M.D.