Welcome!

THE JOHNS HOPKINS
METABOLIC BONE & OSTEOPOROSIS CENTER
FIRST VISIT QUESTIONNAIRE

NAME_____ DATE_____

YOUR DATE OF BIRTH_____ AGE_____

YOUR DIAGNOSIS OF METABOLIC BONE DISEASE

1. When were you diagnosed with bone disease? _____

2. How were you diagnosed with bone disease? _____

3. What was the date of your last bone density test (DXA scan)? _____

4. Has there been a change in bone density since diagnosis? (if yes, explain) _____

5. Do you have any specific concerns you would like to discuss today with the doctor? _____

_____

FRACTURE HISTORY

1. Have you ever broken a bone? (circle one) **NO** **YES** (if yes, please complete below)

Fracture site	How did it occur?	Date / Age?	Surgery required?	Complications?
a.				
b.				
c.				
d.				

BONE MEDICATIONS

1. Are you *currently* on medication for you bones? (circle one) **NO** **YES** (Date started: _____)

(*Examples* of medications: alendronate/Fosamax, zoledronic acid/Reclast, denosumab/Prolia, teriparatide/Forteo, etc.)

- If **yes**, which medication are you taking? _____

2. Have you taken a medication for your bones in the *past*? (circle one) **NO** **YES** (if yes, please complete below)

Medication	Dates	Reason stopped?	Side effects?
a.			
b.			
c.			
d.			

PLEASE DESCRIBE YOUR DIET

1. Special dietary considerations (vegetarian, vegan, gluten-free, etc.)?

2. Sources of **calcium** in the diet:

Food	Frequency? (indicate # servings per day or week)
• Milk (cow, soy, almond, etc.)	_____
• Yogurt	_____
• Cheese	_____
• Leafy greens	_____
• Nuts	_____
• Fortified orange juice	_____
• Other? (please specify)	_____

3. Sources of **protein** in the diet:

Food	Frequency? (indicate # servings per day or week)
• Lean meat (chicken, turkey)	_____
• Red meat	_____
• Fish	_____
• Tofu	_____
• Eggs	_____
• Other? (please specify)	_____

PLEASE DESCRIBE YOUR SUPPLEMENTS

1. Do you take nutritional supplements? (circle one) **NO** **YES** (if yes, describe below)

Supplement	Dose? (indicate # times per day)
• Calcium (citrate or carbonate?)	_____
• Vitamin D3	_____
• Vitamin D2 (Ergocalciferol)	_____
• Multivitamin	_____
• Other supplements (please list):	_____

HEIGHT AND WEIGHT

1. Have you lost height? (circle one) **NO** **YES** (if yes, how much?) _____
2. Have you had a large shift in weight? (circle one) **NO** **YES** (if yes, explain) _____

HOW MUCH DO YOU EXERCISE?

1. Do you exercise on a regular basis? (circle one) **NO** **YES** (if yes, describe below)

Type of exercise — Time and frequency (ex: 30 minutes, 3x weekly)

a. _____ _____

b. _____ _____

c. _____ _____

DEVELOPMENTAL HISTORY

1. Did you have a healthy childhood (active, rare illness, etc.)? (circle one) **YES** **NO** (if no, describe below)

Childhood comments: _____

For women:

- Age of first menstrual period: ____ Were menses regular/predictable? (circle one) **YES** **NO**
- Age of menopause, if applicable: _____ Use of hormone replacement? (circle one) **YES** **NO**
- Challenges with fertility, if applicable?: (circle one) **YES** (if yes, explain) _____ **NO**

For men:

- Have you ever been diagnosed with low testosterone? (circle one) **NO** **YES** (see below)
- If **yes**, were you treated with testosterone replacement? (please explain) _____
- Challenges with fertility, if applicable?: (circle one) **YES** (if yes, explain) _____ **NO**

OTHER RELEVANT HISTORY

1. Do you smoke or have you ever smoked cigarettes? **NO** **YES**

If **yes**, explain: _____

2. Do you drink alcohol? **NO** **YES**

If **yes**, explain (drinks/week, heavy in past, etc.): _____

3. Have you been treated with steroids (prednisone, dexamethasone, etc.) for > 3 months? (circle one) **NO** **YES**

If **yes**, explain: _____

4. Have you been on anti-seizure medications in the past or currently? (circle one) **NO** **YES**

If **yes**, explain: _____

3. Do you have a history of kidney stones? (circle one) **NO** **YES**

If **yes**, explain: _____

4. Please circle any additional diagnoses you have been given and explain, if applicable:

Celiac disease Thyroid disease Cushing's disease Rheumatologic disease

Explanation: _____

FAMILY HISTORY

1. Has your mother or father ever been diagnosed with / treated for osteoporosis? **NO** **YES**

If **yes**, explain: _____

2. Has your mother or father ever had a fracture? **NO** **YES**

If **yes**, explain: _____

1. Has a family member ever been diagnosed with / treated for kidney stones? **NO** **YES**

If **yes**, explain: _____

PAST MEDICAL HISTORY

Please list prior medical diagnoses and date of diagnosis:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

COMMENTS:

PAST SURGICAL HISTORY

Please list prior surgeries and date of surgery:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

COMMENTS:

SOCIAL HISTORY

1. Are you currently (circle one): Single Married In committed relationship Prefer not to say
2. Do you have children? **NO** **YES** (indicate number) _____
3. Are you currently working? **NO** **YES** (see below) **RETIRED** (see below)

If **yes** or retired, what is/was your profession? _____

4. What are your hobbies and interests? What do you enjoy doing? _____

_____

REVIEW OF SYSTEMS

Eyes:	blurred vision	loss of vision	dry eye
Ear, nose, throat:	sinus pain	dental problems	difficulty swallowing
Cardiovascular:	chest pain	swelling of the legs	pain in the calves
Respiratory:	shortness of breath	wheezing	snoring at night
GI:	nausea and/or vomiting	diarrhea	constipation
GU:	excessive thirst	frequent urination	frequent urinary tract infections
Men:	decreased libido	difficulty with erections	decreased need for shaving
Women:	decreased libido	hot flashes	increased facial hair
Nerves:	numbness in feet	dizziness on standing	burning in hands or feet
Skin:	frequent rashes	easy bruising	abnormal moles
Musculoskeletal:	joint pain	muscle pain	decreased muscle mass
	If so, what location? _____		

Psych: Over the last 2 weeks, how often have you had reduced interest in doing what you enjoy (circle one) :
not at all several days more than half the days nearly every day

On a scale of 0 (none) to 10 (severe), how would you rate your **pain** today? _____

MEDICATIONS AND NUTRITIONAL SUPPLEMENTS

Please list all of your <u>medications</u> (prescribed by a physician)

	MEDICATION NAME	DOSE	FREQUENCY
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

Please list all of your <u>nutritional supplements</u> (over the counter, health food store, etc.)

	SUPPLEMENT NAME	DOSE	FREQUENCY
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____