Welcome Back!

THE JOHNS HOPKINS
METABOLIC BONE & OSTEOPOROSIS CENTER
RETURN VISIT QUESTIONNAIRE

NAME_____ DATE_____

YOUR DATE OF BIRTH_____ AGE_____

YOUR DIAGNOSIS OF METABOLIC BONE DISEASE

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

2. Did you have a bone density test prior to your visit today (DXA scan)? **NO** **YES** (date/location) _____

3. Did you have labs drawn prior to your visit today? (circle one) **NO** **YES** (date) _____

FALLS AND FRACTURES

1. Have you fallen since your last clinic appointment? **NO** **YES** (see below)

   If **yes**, please explain: _____

2. Have you broken a bone since your last appointment? (circle one) **NO** **YES** (if yes, please complete below)

Fracture site	Date?	How did it occur?	Surgery / complications?
a. _____	_____	_____	_____
b. _____	_____	_____	_____

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? (see below) _____
- If denosumab (Prolia) or IV zoledronic acid (Reclast), date of last treatment? _____

2. Any new bone medication side effects, if applicable? _____

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):	_____

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)	_____

HEIGHT AND WEIGHT

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

OTHER RELEVANT HISTORY

1. Any recent or upcoming invasive dental work (root canal, implant, extraction)? (circle one) **NO** **YES** (see below)

If **yes**, explain: _____

2. Are you currently being treated for an infection (UTI, pneumonia, etc.)? (circle one) **NO** **YES** (see below)

If **yes**, explain: _____

3. Have there been any other changes to your health since last visit? (circle one) **NO** **YES** (see below)

If **yes**, explain: _____

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? _____ Where ? _____

MEDICATIONS AND NUTRITIONAL SUPPLEMENTS

Please list all of your <u>medications</u> (prescribed by a physician); *please circle **NEW** medications from last visit*

	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.); *please circle **NEW** supplements*

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