PATIENT HISTORY QUESTIONAIRE.

The Breast Care & Bone Density Centre
Ground Floor - JHB Eye Hospital
13 Waugh Ave, Northcliff, Gauteng 2195
011 782 7345

Name		**Today's date**	
Patient ID		**Sex**	
Current height (cm)		**Date of birth**	
Weight (cm)		**Referring Physician**	
Menopause Age		**Are you pregnant?**	

1	Have you had a previous hip or vertebral fracture?	Yes	No
2	Have you had any fractures during adult life which did not result from significant trauma?	Yes	No
3	Did either of your parents ever had a hip fracture?	Yes	No
4	Do you smoke?	Yes	No
5	Have you ever taken Glucocorticoids?	Yes	No
6	Do you have Rheumatoid arthritis?	Yes	No
7	Do you have secondary osteoporosis (disorders: diabetic / osteogenesis / hyperthyroidism / hypogonadism / menopause < 45y/ malabsorption / liver disease & malnutrition)?	Yes	No
8	Do you drink 3 or more alcoholic drinks per day?	Yes	No
9	Are you being treated for osteoporosis?	Yes	No
10	Have you ever taken one of the following medications? Actonel — Boniva Evista — Forteo Fosamax — HRT Miacacin — Protelos Reclast — Prolia Vit D — Calcium Other	Yes	No
11	Do you have any of the following medical conditions: Anorexia/Bulimia — Any Seizure disorder Asthma/Emphysema — Cancer End stage renal disease — Inflammatory bowel disease Hyperparathyroidism — Hysterectomy Other	Yes	No
12	What was your max height		
13	Do you perform weight bearing exercise regularly?	Yes	No
14	Do you regularly consume dairy products?	Yes	No
15	Do you drink caffeinated beverages?	Yes	No
16	Any contrast examination in last 7 days (Iodine/Barium)	Yes	No

If Female:

17	At what age did your period start?		
18	Are you menopausal?	Yes	No
19	How many full term pregnancies have you had?		
20	Have you missed a period recently?	Yes	No