BONE HEALTH ASSESSMENT

NAME:

Age: Weight: Height (at your tallest): Height (current):

Have you fractured a bone as an adult?	YES	NO	Location: Date:
Any family history of fractures due to osteoporosis?	YES	NO	
Do you now, or have you ever smoked cigarettes?	YES	NO	
x_____packs per day x_____number of years?			Quit Date:
Do you drink caffeine?	YES	NO	Amount:
Have you had back surgery?	YES	NO	Date:
Have you had hip surgery?	YES	NO	Date:
Do you have diabetes?	YES	NO	
Do you have Pagets Disease?	YES	NO	
Have you had a Nuc Med study in past 72 hours?	YES	NO	
Have you had a DXA bone density scan in past 2 years?	YES	NO	Date: Where:
Have you been diagnosed with cancer and received radiation?	YES	NO	Date:
Have you had any blood tests in the past 12 months?	YES	NO	When: Where:

Medication History:

Steroids (asthma, lung disease, inflammation)	YES	NO	
Methotrexate	YES	NO	
Anticonvulsants	YES	NO	
Thyroid Hormones	YES	NO	
Osteoporosis Medication	YES	NO	
Estrogen	YES	NO	

Women:

Are you post-menopausal?	YES	NO	Natural or Surgical What age?

Men:

Have you had your testosterone levels checked?	YES	NO	Level:
Have you been treated for low testosterone?	YES	NO	

****Please bring a list of current medications and a list of current supplements to your appointment**

Scheduled First Appointment with BHC Date: _____Time:_____

Scheduled By:_____ Date:_____

Notes: