HELEN HAYES
HOSPITAL

Helen Hayes Hospital, Route 9W, West Haverstraw, NY 10993

CRCQUEST

Bone Health Questionnaire
Return Visit

Today's Date: _____

DEMOGRAPHICS:

Name: _____

Address: _____

_____

Phone Number (work): _____ Phone Number (home): _____

Age at interview: _____ Birth date: _____ Sex: Male ☐ Female ☐

Race: White ☐ Black ☐ Hispanic (Black) ☐ Hispanic (White) ☐ Asian ☐ Other _____

BROKEN BONES (FRACTURES):

Please list all broken bones (fractures) you have had since 45 (except fingers and toes)

Fracture Site	Year

Have you suffered height loss of 2 inches or more? _____ Yes _____ No

Do you have back pain which limits your activities? _____ Yes _____ No

Have you had any surgeries since your last visit? _____ Yes _____ No

If yes, please describe: _____

_____

_____

Have you had any hospital admissions since your last visit? _____ Yes _____ No

If yes, please describe: _____

_____

_____

OTHER MEDICAL HISTORY:

Since you were last here, have you been diagnosed with any of the following?

						Age
1.	Rheumatoid Arthritis (Not Osteoarthritis)	_____	Yes	_____	No	_____
2.	Inflammatory Bowel Disease (Ulcerative Colitis or Crohn's Disease)	_____	Yes	_____	No	_____
3.	Celiac Disease	_____	Yes	_____	No	_____
4.	Thyroid Disease	_____	Yes	_____	No	_____
5.	Paget's Disease	_____	Yes	_____	No	_____
6.	Kidney Stones	_____	Yes	_____	No	_____
7.	Seizure Disorder (Epilepsy)	_____	Yes	_____	No	_____
8.	Cancer Site of Cancer: _____	_____	Yes	_____	No	_____
9.	Have you had radiation or chemotherapy?	_____	Yes	_____	No	_____
10.	Asthma or Chronic Lung Disease	_____	Yes	_____	No	_____
11.	High Blood Pressure	_____	Yes	_____	No	_____
12.	Diabetes	_____	Yes	_____	No	_____
13.	Scoliosis (Curvature of the Spine)	_____	Yes	_____	No	_____
14.	Eating Disorder	_____	Yes	_____	No	_____
15.	Depression	_____	Yes	_____	No	_____
16.	Other Diseases	_____	Yes	_____	No	_____

Please list:

_____

_____

_____

FAMILY HISTORY OF FRACTURE:

If any of the relatives below have any of the following, **please circle the appropriate choice(s)**.

Relative

Father:	Fracture _____	Height Loss _____	None _____	Don't Know _____
Mother:	Fracture _____	Height Loss _____	None _____	Don't Know _____
Sister(s):	Fracture _____	Height Loss _____	None _____	Don't Know _____
Brother(s):	Fracture _____	Height Loss _____	None _____	Don't Know _____

MEDICATIONS

Have you ever taken any of the following for longer than one month?

					When?
1.	Steroids (e.g. Corisone, Prednisone, Decadron, Medrol)?	_____ Yes	_____ No		_____
2.	Thyroid Hormones or Synthroid				
3.	Drugs for Seizures, Convulsions, Epilepsy	_____ Yes	_____ No		_____
4.	(e.g. dilantin, phenobarbital)				
5.	Drugs for Depression (e.g. SSRIs, Prozac, Zoloft)	_____ Yes	_____ No		_____
6.	Drugs for Reflux, Heartburn, etc. (PPIs)	_____ Yes	_____ No		_____
7.	Drugs for Diabetes (e.g. Actos, Avandia)	_____ Yes	_____ No		_____
8.	Oral Contraceptives	_____ Yes	_____ No		_____
9.	Aromatase Inhibitors (e.g. Femara, Arimidex, Aromasin, etc.)	_____ Yes	_____ No		_____
10.	Depo-Provera	_____ Yes	_____ No		_____
11.	Drugs to treat Prostate Cancer	_____ Yes	_____ No		_____
	Estrogens (e.g. Premarin, Estraderm, Estrace, Vivelle)	_____ Yes	_____ No		_____
	If yes, for how long? _____				
12.	Are you currently taking estrogen?	_____ Yes	_____ No		_____
	Alendronate (Fosamax)	_____ Yes	_____ No		_____
	If yes, for how long? _____				
13.	Are you currently taking Alendronate (Fosamax)?	_____ Yes	_____ No		_____
	Risedronate (Actonel)	_____ Yes	_____ No		_____
	If yes, for how long? _____				
14.	Are you currently taking Risedronate (Actonel)?	_____ Yes	_____ No		_____
	Ibandronate (Boniva)	_____ Yes	_____ No		_____
	If yes, for how long? _____				
	Are you currently taking Ibandronate (Boniva)?	_____ Yes	_____ No		_____
15.	Do you take oral or IV Boniva? _____ Oral _____ IV	_____ Yes	_____ No		_____
	Zeledronic Acid (Reclast)	_____ Yes	_____ No		_____
	If yes, how many treatments have you had? _____				
16.	When was your last treatment? _____				
	Raloxifene (Evista)	_____ Yes	_____ No		_____
	If yes, for how long? _____				
17.	Are you currently taking Evista?	_____ Yes	_____ No		_____
	Teriparatide (Forteo)				
	If yes, for how long? _____				
	Are you currently taking Forteo?	_____ Yes	_____ No		_____
18.	Prolia	_____ Yes	_____ No		_____
	If yes, for how long? _____				
	Are you currently taking Prolia?	_____ Yes	_____ No		_____

LIFESTYLE/PERSONAL HABITS:

1. Have you ever smoked one of more cigarettes per day for at least six months? _____ Yes _____ No
2. For how many years in total have you smoked or did you smoke at least one cigarette a day? _____ years
3. On average, for the time that you smoked, how many cigarettes did/do you smoke a day?
   _____ cigarettes per day
4. In the past year, how often did you drink:

	Enter Number:	Circle One:		
A can or bottle of beer	_____ times per	DAY _____	WEEK _____	MONTH _____
A glass of wine or sherry	_____ times per	DAY _____	WEEK _____	MONTH _____
Hard liquor or a mixed drink	_____ times per	DAY _____	WEEK _____	MONTH _____

CALCIUM/VITAMIN D INTAKE:

Please fill in the number of servings you consume of each of the following foods.

Food Item	**Number of Servings**	**Circle One**
1. Milk (8 oz)	_____ per	DAY _____ WEEK _____ MONTH _____
2. Yogurt (8 oz)	_____ per	DAY _____ WEEK _____ MONTH _____
3. Cheese & mixed cheese dishes	_____ per	DAY _____ WEEK _____ MONTH _____

One serving equals 1 ounce, 1 slice, or 1.5" cube hard cheese, 1/3 cup ricotta cheese or yogurt cheese, 1 cup fortified cottage cheese (not regular cheese), 1 cup mixed cheese dishes (macaroni and cheese, cheese souffle, lasagna, manicotti, ziti, quiche), one slice of pizza.

Calcium-Fortified Foods (most juices and cereals are not fortified; please check label):

4. Calcium-fortified juice (8 oz)	_____ per	DAY _____ WEEK _____ MONTH _____
5. Calcium-fortified cereal	_____ per	DAY _____ WEEK _____ MONTH _____

e.g. (Total) or other fortified foods containing >250 mg per serving
(don't include non-fortified cereal)

Please use the labels on your vitamin or supplement containers to complete the following sections:

6. Are you currently taking calcium supplements: _____ Yes _____ No
   If yes, which one do you take? _____
   How many mg of calcium does each tablet contain? _____ mg
   Does this supplement contain vitamin D? _____ Yes _____ No
   If yes, how many IU of vitamin D does it contact? _____ IU
   How many tablets of this supplement do you take each day? _____ per day
7. Do you take a daily multivitamin? _____ Yes _____ No
   If yes, how much calcium does each tablet/capsule contact? _____mg
   How many tablets/capsules do you take each day? _____ per day
8. Do you take a separate vitamin D tablet? _____ Yes _____ No
   If yes, how much does it contain? _____ How often do you take it? _____
9. Do you take a supplement containing Strontium _____ Yes _____ No
   If yes, how much does it contain? _____ How often do you take it? _____

PHYSICAL ACTIVITY:
As exercise is important for your bones, we would like to know how much physical activitity you currently engage in and how much you participate in in the past.

Current Physical Activity:
1. The following items are about activities you might do during a typical day. Does your health or pain now limit you in these activities? If so, how much?

Activities	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited at All
a. Vigorous activities such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking more than a mile	1	2	3
h. Walking several blocks	1	2	3
i. Walking one block	1	2	3
j. Bathing or dressing yourself	1	2	3

2. Do you need your arms to assist yourself in standing up from a chair? _____ Yes _____ No
3. How many times have you fallen in the past year? Never _____ 1 _____ 2 _____ 3 or more _____
4. How many times do you remember falling in the past 5 years? Never _____ 1 _____ 2 _____
3 or more _____

FOR FEMALE PATIENTS ONLY:

1. How old were you when you had your first menstrual period? _____ years
2. Before menopause, aside from times you were pregnant, how often did you miss you period for 20 months or more in a row? _____ times
   What was the longest interval between periods? _____ months
3. Including any live births, still births, and miscarriages, how many times have you been pregnant? _____
   How many live births? _____ children
4. How many months (total) did you breastfeed your children? _____ months
5. Have you reached menopause of stopped menstruating? _____ Yes _____ No
   If yes, at what age? _____
6. Have you ever had a hysterectomy (an operation to remove your uterus?) _____ Yes _____ No
   If yes, at what age? _____
7. Have you ever had both ovaries removed? _____ Yes _____ No
   If yes, at what age? _____
8. If you have not stopped menstruating or are currently going through menopause, how many menstrual cycles have you had in the past year? _____ cycles