

**CONCORD ORTHOPAEDICS
RHEUMATOLOGY
METABOLIC BONE DISEASE**

264 Pleasant Street
Concord, NH 03301
(603) 224-3368

Dear Patient,

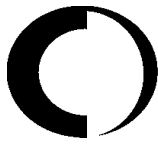
You were recently schedule for an appointment at Concord Orthopaedics for a bone density study to evaluate for osteoporosis. We would like to welcome you and give you some information about what will occur during your visit.

Osteoporosis is a disease that causes bones to become fragile, making them more likely to break. If left untreated, osteoporosis progresses silently until a bone breaks. The good news is that individuals can take steps to prevent, diagnose, and treat this debilitating disease.

Enclosed is an osteoporosis questionnaire. Please take the time to answer all the sections completely and as accurately as you can. A complete medication list, including vitamins and herbal preparations is essential. You may list these medications on the form or bring them with you on the day of your appointment. If you take a calcium supplement please discontinue it 48 hours prior to the study. Please wear pants with an elastic waist band, or you may need to change into shorts at the time of your exam. Please no underwire bra.

We will review the questionnaire with you and then perform the test called a DEXA scan. This is not the same as a bone scan. It is quick and non-invasive. Dr. Shirley, Dr. Phillips, and Dr. Orzano will then discuss the results of the test as well as any further evaluation and/or treatment needed.

Please feel free to contact one of our Patient Care Coordinators, Becky or Lisa, if you have any questions. We look forward to seeing you at your appointment.



CONCORD ORTHOPAEDICS

Osteoporosis Questionnaire

Name: _____ DOB _____ Date: _____

Primary Care Physician: _____

Is there a chance you are pregnant? Yes No

Have you have a nuclear scan in the last week? Yes No

Have you had an x-ray with barium or dye in the last 2 weeks? Yes No

If you answered YES to any of the above questions, please inform the staff promptly.

Gender: Male Female

Ethnicity: Caucasian Black Asian Hispanic Other

Your tallest height? (late teens / early adult height) _____

RISK FACTORS FOR FALLS

Have you fallen in the past year? Yes No

Do you have a problem with: Dizziness Balance Vision

Broken bones from minimal or no trauma? (check all that apply):

Hip Pelvis Wrist Shoulder Spine

FAMILY HISTORY

Do you have a family history of osteoporosis? Yes No

Any relative with hip fractures? Yes No If yes, who: _____

DIETARY HISTORY AND LIFESTYLE FACTORS

How many servings of dairy do have daily? _____

Do you take a calcium supplement? Yes No If yes, how much? _____

Do you take a vitamin D supplement? Yes No If yes, how much? _____

How many alcoholic beverages do you consume in a week? _____

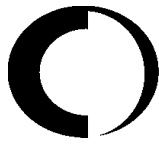
How many caffeinated beverages do you consume daily? _____

Do you exercise? Yes No If yes, how and how often? _____

Do you use tobacco products? Yes No

MEDICAL HISTORY

- | | | |
|---|--|---|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Paget's Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Cushing's |
| <input type="checkbox"/> Overactive Thyroid | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Osteogenesis Imperfect |
| <input type="checkbox"/> Cancer: Type _____ | | |



CONCORD ORTHOPAEDICS

Osteoporosis Questionnaire

SURGICAL HISTORY Check all that apply:

- Thyroid Surgery Parathyroid Spine surgery Hip surgery RT LT
 Removal of uterus Date: _____ Kyphoplasty
 Removal of ovaries: One Both Date: _____

MEDICATIONS

Have you ever taken any of the following medications?

- | | |
|---|--|
| <input type="checkbox"/> Prednisone or other steroid | <input type="checkbox"/> Pamidronate |
| <input type="checkbox"/> Seizure medicine which one(s) _____ | <input type="checkbox"/> Zoledronic acid (Reclast, Zometa) |
| <input type="checkbox"/> Thyroid hormone | <input type="checkbox"/> Raloxifene (Evista) |
| <input type="checkbox"/> Alendronate (Fosamax) | <input type="checkbox"/> Teraperatide (Forteo) |
| <input type="checkbox"/> Residronate (Actonel) | <input type="checkbox"/> Nasal Calcitonin (Myacalcin) |
| <input type="checkbox"/> Ibandronate (Boniva) | <input type="checkbox"/> Estrogen / HRT |
| <input type="checkbox"/> Prolia | |

FOR WOMAN

- Are you still having menstrual periods? Yes No
 Do/did you have irregular menses? Yes No
 Age with first menstrual period? Yes No
 Age with last menstrual period? _____
 Have you taken birth control pills? Yes No
 Have you been on hormonal replacement? Yes No
 If yes, currently? _____ For how many years? _____

FOR MEN

- Do you have low testosterone (male hormone)? Yes No Unknown
 Do you have decreased libido? Yes No