HOSPITAL
FOR
SPECIAL
SURGERY

BONE HEALTH QUESTIONNAIRE

Marci Goolsby, M.D.

Patient Name:____

Have you ever had a fracture (broken bone)? YES NO
If so, what bone and when? ____
Have you ever had a stress fracture? YES NO
If so, what bone and when? ____
If you currently have a stress fracture, what has been done for your treatment?
Activity allowed: ____
Medications: ____
Bone stimulator: ____
If you have pain with activity, at which point? i.e. during activity, after activity, all the time?
____

Menstrual History:
How old were you when you started your period? _____________________________
Do you get regular periods every month? YES NO
If no, how many days between your periods? ____________________________
How many periods have you had in the last 12 months? ________________________
Are you on birth control pills or have an IUD in place? YES NO
If yes, which and for how long? ____
In the past, did you ever have irregular periods? YES NO
If yes, please describe: ____
Have you ever been pregnant? YES NO
If so, how many times? ______ How many children do you have? ______

Diet History:
Have you ever dieted? YES-Describe____________ NO
Is there anything you avoid eating? YES-Describe____________ NO
Have you ever taken diet pills or laxatives? YES-Describe____________ NO
Have you ever made yourself vomit? YES-Describe____________ NO
Do you binge eat? YES-Describe____________ NO
Do you exercise excessively to lose weight? YES-Describe____________ NO
Has your weight fluctuated over the last few years? YES-Describe____________ NO
What is your highest weight in the last 5 years? _________________________________
What is your lowest weight in the last 5 years? __________________________________
Please describe in detail an average day's food and drink intake:_____________________
____
____
____

Medical History:

Do you have celiac disease?	YES	NO
Do you not tolerate or avoid certain foods?	YES	NO
Do you have ongoing stomach or digestion problems?	YES	NO
Have you had any thyroid problems?	YES	NO
Have you ever had a kidney stone?	YES	NO

Please list any prescription medications you take: ____

Please list any over the counter medications or vitamins or supplements you take, including pain medicine: ____

Do you take calcium and/or vitamin D pills or chews? YES NO

If so, which kind and how often? ____

Do you have osteopenia or osteoporosis? YES NO

Have you ever had a bone density test (DXA scan)? YES NO

If so, when? ____

Have you ever been a smoker or heavy drinker? YES NO

If so, how many a day and for how long? ______________________________________

Family History:

Osteoporosis	YES-Describe___________	NO
Hip fracture	YES-Describe___________	NO
Bone disease	YES-Describe___________	NO
Kidney stones	YES-Describe___________	NO
Parathyroid disease	YES-Describe___________	NO
Eating disorder	YES-Describe___________	NO

What is your ethnic background?____

Training History:

Please write out your typical exercise routine and include duration or distance of each activity and times per week.____

____

____

____

How many days per week do you rest from exercise, if any? ___________________________

How long have you had your current running shoes? _________________________________

If you wear orthotics/shoe inserts, how long have you had these? ______________________

Have you ever had a gait analysis? YES NO

Do you experience more fatigue than you would normally expect? YES NO

Signed by patient:_________________________________ **Date:**______________________

Reviewed by Dr. Goolsby:____