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___________________________________________

Is there anything you avoid eating? YES-Describe_______________________________

Have you ever taken diet pills or laxatives? YES-Describe________________________

Have you ever made yourself vomit? YES-Describe_____________________________

Do you binge eat? YES-Describe_______________________________________________

Do you exercise excessively to lose weight? YES-Describe________________________

Has your weight fluctuated over the last few years? YES-Describe_________________

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: _________________________________________________________