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BONE HEALTH PATIENT INTAKE

Name:_____ DOB:_____ Height as a young adult: ___ Feet ___Inches

Fracture/Fall/Osteoporosis History	**YES**	**NO**
Do you have a history of a bone fracture(s) that resulted from a fall from standing height?		
Have you fallen 1 or more times in the past year? Number of times?___		
Have you ever been diagnosed with osteoporosis or low bone mineral density?		
Have you taken medication for osteoporosis in the past? Date /Year of last dose?_____		
Family Medical History		
Do you have a parent or sibling with a diagnosis of osteoporosis?		
Have on either your parents or siblings suffered a fracture in a fall from standing height?		
Medical History – Do you have a history of any of the following:	**YES**	**NO**
Diabetes?		
Rheumatoid Arthritis?		
Vitamin D deficiency?		
Neurological Disorder (Stroke, Parkinson's Disease, Multiple Sclerosis, etc.)		
Gastrointestinal Disease (Reflux, Esophagitis, Irritable Bowel Syndrome, Celiac Disease)?		
Breast or Prostate Cancer?		
Significant dental disease (gum disease, loose teeth, abscesses/infections, cavities)?		
In the last 6 months have you had a tooth pulled or a dental implant placed?		
Do you plan to have a dental extraction or implant in the next 6 months?		
Early menopause (natural or due to surgery, before age 45)?		
Taking steroids pills (prednisone) for greater than 3 months?		
Significant health problems in your teens or twenties?		
Nutrition History	**YES**	**NO**
Do you have any food allergies, intolerances, or restrictions?		
Do you routinely take calcium supplements?		
Do you routinely take Vitamin D supplements?		
Exercise History	**YES**	**NO**
Do you routinely participate in weight-bearing exercise like walking, running or lifting weights?		
Do you have any conditions that restrict your ability to walk for exercise?		
Lifestyle History	**YES**	**NO**
Are you a current or past smoker? If yes, how many years____		
Do you typically drink 3 or more alcoholic drinks a day?		

Diet Recall: Use your best estimate on a typical day	**Number of Servings Daily**
Cow's Milk	8 oz glasses ____
Vegetable Based Milk (soy, almond, oat)	8 oz glasses_____
Yogurt Individual service size container	Containers _____
Hard Cheese 4-ounce servings	Servings_____
Ice cream 4 ounce serving (small bowl)	Servings _____