Wellness Center Inside Outside® Medical Spa

4499 Medical Drive, Suite 225
San Antonio, Texas 78229

"A Whole New You"
Charles B. Christian, Jr., M.D., Medical Director

Telephone (210) 616-0836
Fax (210) 616-0586

OSTEOPOROSIS DATABASE QUESTIONNAIRE

Date __/__/__

Pt. # _____

Your Name:		
Social Security #:	Date of Birth:	Age:
Address:		
City:	State:	Zip:
Your Home Phone:	Your Work Phone:	
Your Doctors Name:		
At your tallest, what was your height in feet and inches?		
If you are still menstruating, what was the date of your last period?		
If passed menopause, estimate the age you last had a menstrual period?		
How many children have you given birth to?		
Email:	Would you like to receive our quarterly newsletter?	

Below, please list all medications (prescription and over-the-counter), vitamins and mineral supplements, natural herbs or drugs, and homeopathic therapies you are currently taking.

Medication Name	Dose	Number taken daily

Risk Factors We Can't Change (Unavoidable)

Please circle the number or check the box by any condition that applies to you now or in the past.

Personal History

10	I am Female	11	I am over 50 years old
275	I am Male	65	I have a family history of osteoporosis
90	I am Caucasian (white)	120	I have lost a little height in the last 5-10 years
285	I am African-American (black)	12	I have weighed less than 127lbs most of my life
95	I am Asian (oriental)	13	I have thin and small bones
290	I am Hispanic		
105	I am of Northern European Ancestry		

Medical History

245	I have history of a kidney stone	325	I have had a spine compression fracture
70	I have a history of an over-active thyroid gland	320	I have had a wrist fracture
395	I have a history of phlebitis	330	I have had a hip fracture
400	I have a history of pulmonary embolism	335	I have had a rib fracture
430	I have a history of a low thyroid gland	340	I have had a pelvic fracture
240	I have a history of a high blood calcium level	345	I have had a stress fracture ( )
75	I have a history of hyperparathyroidism	350	I have had a fracture not listed above ( )
420	I've been told I have osteoporosis/osteopenia	631	I have a history of kidney failure
425	I have back pain	191	I have a history of kidney transplant
436	I have scoliosis	633	I am on kidney dialysis
140	I have a history of multiple myeloma	192	I have a history of heart transplant
45	I have a history of alcoholism	155	I have a history of anorexia nervosa or bulimia
50	I have rheumatoid arthritis	520	I have a history of intestinal malabsorbtion
380	I have Type 1 Diabetes	521	I have had intestinal bypass surgery
	I have Type 2 Diabetes	220	I have inflammatory bowel disease
438	I have a history of Back Surgery	439	I have a histoy of Hip Surgery R or L

Female Reproductive System History

15	I had a premature menopause, before age 40	25	I have a history of amenorrhea
20	I have passed menopause	415	I had a hysterectomy (surgical removal of uterus)
25	I lost my periods for a while at some time	390	I have a history of cervical or uterine cancer
40	My periods began after age 16	361	I have fibrocystic breast disease
160	I lost periods due to a heavy exercise routine	405	I have a history of breast cancer
165	I had both ovaries removed surgically	363	I have a family history of breast cancer
35	I have a history of irregular menstrual periods	360	I have uterine fibroids

Medication History Or Present Use

60	I have used cortisone-like drugs (prednisone)	170	I have used thyroid hormone pills
200	I have used phenobarbital or Dilantin for seizures	180	I have a history treatment for cancer with chemotherapy (Methotrexate especially)
220	I use Mylanta or Maalox (With Aluminum)	235	I have used anti-rejection drugs for transplant
300	I have used Lasix for hi blood pressure	485	I have used heparin to prevent blood clotting
904	I have used Chloestyramine for cholesterol	618	I have used Fosamax or Actonel
900	I have used Estrogen Pills after menopause	960	I have used Testosterone
	I have used Growth Hormone		I have used Statin drugs

Risk Factors that we can Control (Avoidable)

Diet and Lifestyle History			
225	I usually eat meat twice daily	305	I exercise 3 or more times weekly
235	I follow a vegetarian diet	110	I don't exercise regularly
80	I use 2 or more alcoholic drinks daily	210	I use 2 or more soft drinks daily
310	I regularly include dairy in my diet	215	I use of 2 or more cups of coffee or tea daily
195	I avoid milk and other dairy foods	85	I have used Tobacco regularly in the past
990	I have a lot of stress in my life	991	I get less than 8 hours sleep usually

Voluntary Patient Disclaimer Regarding Pregnancy

I, _____, hereby state that I have been instructed by the staff of Inside Outside Wellness Center & Medical Spa that DXA Body Composition and Bone Densitometry testing is an elective procedure and that I must NOT have a DXA Scan performed if I am pregnant, or have any suspicion that I may be pregnant. I have instructed the staff of Inside Outside Wellness Center & Medical Spa that I am not pregnant, do not have any suspicion I may be pregnant, and I have elected to have this procedure performed today. Should it be determined at a later date that I am pregnant at the time the scan was performed, I agree to hold Inside Outside Wellness Center & Medical Spa, and any partners/affiliates of Inside Outside Wellness Center & Medical Spa, harmless from any liability and any potential future damages.

Signature:

_____

Date:_____

Nurse/Doctor Notes:

_____

_____

_____

_____

_____

_____

_____

Today's weight _____ Patient's Maximum Weight _____

Today's height _____