Name:
DOB:
Chart:
Age:
Date:

BAYSIDE ORTHOPAEDIC
SPORTS MEDICINE & REHAB CENTER

FRACTURE LIASON SERVICES QUESTIONNAIRE:

1. Name of provider who referred you today _____

2. Have you had height loss or become shorter since your 20's?
    a. NO
    b. YES- How much, in your best estimate? _____inches

3. If female: Are you still having periods?
    a. YES
    b. NO- Menopause naturally. At what age?_____
    c. NO- Surgical hysterectomy. At what age?_____
        i. Total hysterectomy
        ii. Partial hysterectomy (No ovaries removed)

4. If male: Have you ever been told you have low testosterone?
    a. NO
    b. YES

5. Have you ever had hormone replacement therapy?
    a. NO
    b. YES
        i. Therapy type_____
        ii. Duration of treatment?_____

6. Are you a vegetarian or vegan?
    a. NO
    b. YES

7. Do you currently smoke?
    a. NO
    b. YES, Packs smoked per day_____. How long have you smoked?_____
    c. History of smoking
        i. Quit smoking: Year_____
        ii. How long did you smoke before quitting? _____

8. Do you drink alcohol?
    a. NO
    b. YES. How many drinks per week?_____

9. How many caffeinated beverages do you have a day? (1 serving=8oz) _____

10. Have you had any falls in the past year?
    a. NO
    b. YES. How many? _____

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11. How active have you been in the last 12 months? (prior to injury)
    - ☐ Not able to walk/Not active (walking less than a mile or 5,000 steps a day)
    - ☐ Somewhat active (walking some but less than 2 miles or around 10,000 steps a day)
    - ☐ Very active (walking 2 or more miles or more than 10,000 steps a day)

12. Have you ever been diagnosed with any of the following diseases or disorders?

☐ Rheumatoid Arthritis	☐ Lupus
☐ Celiac Disease	☐ Inflammatory Bowel Disease
☐ Gastric Bypass	☐ COPD
☐ GERD (heartburn or acid reflux)	☐ Parathyroid or thyroid gland
☐ Diabetes 1 or 2	☐ Seizure Disorder
☐ HIV/AIDS	☐ Paget's Disease
☐ Depression	☐ Stroke
☐ Parkinson's Disease	☐ Multiple Sclerosis
☐ Hepatitis B or C	☐ Kidney Stones
☐ Lactose intolerance	☐ Osteogenesis imperfecta

13. Have you ever been diagnosed with cancer?
    a. NO
    b. YES. What kind_____
        i. Did you ever have radiation therapy?
            1. NO
            2. YES

14. Have you ever been diagnosed with chronic kidney disease?
    a. NO
    b. YES. What stage and who is your nephrologist? _____

15. Did either of your parents have a hip fracture after the age of 50?
    a. NO
    b. YES. Who? _____
    c. Unknown

16. Do you know of any family members with osteoporosis?
    a. NO
    b. YES. Who? _____
    c. Unknown

17. Did you have a recent fracture?
    a. NO
    b. YES. Which bone? _____ What date? _____

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18. Have you broken a bone since 50 years of age?
    a. NO
    b. YES. What did you fracture and at what age? (please list all)

    _____

19. Are you currently or have you ever taken any medication for bone loss? **Yes/No**

20. Are you currently or have you ever taken any of the following medications? If yes, please state how long?

Fosamax (Alendronate)_____	Didronel (Etidronate) _____
Boniva (Ibandranate) _____	Aredia (Pamidronate) _____
Actonel (Risedronate) _____	Reclast(Zoledronate) _____
Zometa (zolendronic acid)_____	Fortical(Calcitonin) _____
Miacalcin (nasal spray) _____	Evista (Raloxifene) _____
Forteo (Teriparatide) _____	Tymlos (Abaloparatide) _____
Prolia (Denosumab) _____	Evenity (romosozumab) _____

21. Have you ever been told you have low or high calcium levels?
    a. NO
    b. YES. High or Low? _____

22 Have you ever had **LOW** Vitamin D levels?
    1. NO
    2. YES

23. Are you taking the following nutritional supplements?
    a. CALCIUM
        i. NO
        ii. YES Please list dosage and how often you take. _____
    b. Vitamin D
        i. NO
        ii. YES Please list dosage and how often you take. _____

24. Have you had a Bone Density Scan or DXA in the past 2 years?
    a. NO
    b. YES. Where? _____ Do you know your last T-score? _____

25. How often do you see a dentist?
    a. Every 6 months
    b. Once a year
    c. Only as needed. Last visit was _____ years ago (approximately).

26. Have you ever or are you currently taking any of the following medications? Include how long you have been taking these medications? **(please circle all that apply)**

Anticonvulsants: (Gabapentin, Lyrica, Lamictal, Dilantin, Neurantin, Phenobarbital) _____
Anticoagulants: (Heparin, Warfarin, Plavix)_____
Chronic pain medication: (Opiods: oxycodone/oxycontin, Percocet, hydrocodone) _____
Oral Steroids: (Prednisone) _____
Inhaled Steroids: (Advair, Symbicort, Qvar, Flovent)_____
Stomach medications: (Omeprazole, Prilosec, Protonix, Lansoprazole, Pantoprozole, Nexium) _____
Depression medications: (Lexapro, Celexa, Sertraline, Zoloft, citalopram, Lithium) _____
Arthritis medications: (Plaquenil, Methotrexate, Remicade, Embrel, Humira)_____