Name:
DOB

Calcium, Parathyroid, or Osteoporosis Previsit Questionnaire

Since your last appointment in this office have you:	NO	YES	If new issue, please explain:
Taking calcium supplements? (if yes, how much how often)	____	____	_____
Taking vitamin D supplement? (if yes, how much how often)	____	____	_____
Consuming dairy (milk, yogurt, cheese- if yes, how much/often)	____	____	_____
Any new balance issues or falls?	____	____	_____
Any new broken bones?	____	____	_____
Any new kidney stones or blood in urine?	____	____	_____

Regarding symptoms/problems:

Rate average energy past week (1=low, 10= high): _____/10

	No Problem	Yes, same	New Prob	Please explain:
a) Fevers				
b) Sweats				
c) Intolerance of heat or cold				
d) Trouble Swallowing				
e) Changes in voice				
f) Changes in hearing				
g) Chest Pains				
h) Heart Racing				
i) Swelling in legs (edema)				
j) Shortness of breath				
k) Cough				
l) Nausea or Vomiting				
m) Abdominal Pain				
n) Discomfort with urination				
o) Swelling or pain in joints				
p) Balance problem or falls				
q) Difficulty with memory				
r) Tremor				
s) Headache				
t) Skin rash or lesions				
u) Hair loss				
v) Bleeding/Bruising				
w) Allergic reactions				
x) Anxiety				
y) Depression				
z) Men: Erectile Dysfunction Women: Menstrual Change				

How often/much do you: wake up night to urinate?_____/night.

have a bowel movement? ____/day OR_____/week

Smoking: Packs per day: _____ or per week _____ OR NEVER _____

Alcohol Consumption drinks per day: _____ OR per week _____ OR Never _____