Name: ______________________________

Date of Birth: ______________________________

Today's Date: ______________________________

Calcium, Osteoporosis, Kidney Stones, Mineral Disorders

1. Calcium supplement? **YES/ NO**, ______mg/day,_______days per week
   What type of calcium (circle): carbonate, citrate, phosphate, combination
2. Vitamin D pill too? **YES/ NO**, ______units/day, _______days per week
3. Calcitriol? **YES/ NO** _______ mcg/day, _______days per week
4. Magnesium? **YES / NO**, ______mg/day, _______days per week
5. Potassium citrate? **YES / NO**, ______mEq/day, _______days per week
6. Hydrochlorothiazide? **YES / NO**, ______mg/day, _______days per week
7. Other diuretic **(circle if yes)**? Indapamide, Furosemide, Torsemide
8. Osteoporosis Meds **(circle if yes)**? Aldendronate (Fosamax), Risedronate (Actonel), Ibandronate (Boniva), Zolendronic Acid (Reclast), Raloxifene (Evista), Denosumab (Prolia), Teriparatide (Forteo), Abaloparatide (Tymlos)

9. **Let's figure out your calcium intake from the diet:**
   - Milk (oz per day, # times per week): _________ , ______________
   - Yogurt (oz per day, # times per week): _________ , ______________
   - Cheese (oz per day, # times per week): _________ , ______________
   - Cottage cheese (oz per day, # times per week): _________ , ______________
   - Ice cream (oz per day, # times per week): _________ , ______________
   - Calcium fortified liquids including orange juice, almond milk, soy milk, boost, protein bars, etc.:
   __________________ , ______________________ oz/day, # times per week
   - Calcium fortified foods (bars, etc.) : ______oz/day, ______# times per week

12. Estrogen? **YES / NO** Circle if yes: patch, pill, pellet, injection
13. Meds for heartburn? **YES / NO**
    a. What is the name(s)? __________________
    b. How often do you take this? ______________

(Please fill out second page, either attached or on the back of this sheet of paper) ------------------→

Symptoms and changes since last time:

1. New falls? **YES / NO**

2. New fractures? **YES / NO**

3. Bone or body pain **(circle if yes)**? Back, Hips, Arms, Legs, Other

4. Upcoming dental procedures? **YES / NO** Ulcer on gums? **YES / NO**

5. Circle each symptom you are experiencing as listed below:

- **circle here if NONE of the BELOW**
- heartburn
- abdominal pain
- blood in stool
- black sticky stool
- nausea
- vomiting
- constipation
- new lumps in the bone or skin
- new gout attack
- kidney stone symptoms
- change in ability to concentrate
- numbness or tingling at the fingertips
- numbness or tingling around the lips
- muscle cramps

6. # bowel movements **(circle per day or per week)**? __________ per **DAY / WEEK**

7. How many times do you wake up to urinate? _____________

8. How often do you exercise? ______ times a week
How many minutes? ____________
WALKING / YOGA / JOGGING / SWIMMING / WEIGHTS /
Other: _________________

9. Are you taking Prolia? **YES / NO** If so, any new infections? **YES / NO** Last injection date? ________
Are you taking Reclast? **YES/ NO** If so, last infusion date? _____________

10. For kidney stone formers:
- # hours in the heat per week? ____________
- # handfuls of nuts per week? ____________
- # servings of spinach per week? __________
- # servings of chocolate per week? ___________

11. Are you still menstruating? **YES /NO/NOT APPLICABLE** If so, have your periods changed? **YES / NO**

12. Did you ever have any severe childhood illness? **YES / NO**
Did you ever have a period of prolonged immobilization? **YES / NO**

12. Does anyone in your family have osteoporosis, hip fracture, high calcium, or kidney stones? **YES / NO**
Any **NEW** family history (relevant to bone, calcium, stones)? **YES / NO**