MEDICAL HISTORY QUESTIONNAIRE

LOUISIANA OSTEOPOROSIS STUDY (LOS)

FOR LOS USE ONLY

ID #:
_____

YOU CAN ENROLL IN LOS ONLY ONE TIME.

YOU MUST PROVIDE PICTURE IDENTIFICATION PRIOR TO ENROLLMENT.

FOR LOS USE ONLY

ID#: _____

PERSONAL INFORMATION

Name: _____ Date of Birth: _____/_____/_____

Mailing Address: _____
Street City State ZIP Code

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____

Email: _____

Study ID:

Louisiana Osteoporosis Study

Medical History Questionnaire

Today's date: _____/_____/_____ FOR LOS USE ONLY: Subject ID#: _____
Month Day Year

How did you find out about our study? (Check one)

_____Words of Mouth ____Flyers _____Email ____Newspaper _____Radio _____Other

Have any blood-related relatives been or are any LOS participants? _____

If so, please provide:

Name	**Relationship to You**	**Date of Birth**
_____	_____	_____
_____	_____	_____
_____	_____	_____

(If there are more relatives, please list them at the end of this questionnaire.)

Gender (Circle one): FEMALE/MALE Birth weight: _____ pounds _____ ounces

Race/Ethnic Origin (Check one):	Your annual income (Circle one, optional)	Education (Circle one, optional)
_____African – American/Black	Under $20,000	8th grade or less
_____Asian	$20,000-39,999	Some high school
_____Caucasian/White	$40,000-59,999	High school graduate
_____Hispanic/Latino	$60,000-79,999	Some college
_____Native American/Pacific Islander	$80,000 or more	College graduate
_____Other please specify: _____		Graduate degree

FOR SAFETY, PLEASE VERIFY:

Are you afraid of or have you had issues with having your blood drawn? (Circle one): YES/NO

EMERGENCY CONTACT NAME(S) & PHONE NUMBER(S): _____

_____

FEMALE HISTORY

For purposes of this questionnaire, "period" and "cycle" both refer to menstrual cycle.

Age when you had your first period: _____ Is/Was your cycle regular? (Circle one) YES/NO
(Regular cycle defined as menstrual flow every 21-35 days)

On average, number of cycles per year: _____

Have you ever missed your cycle for a period greater than 6 months except during pregnancy? (Circle one) YES/NO

NOTE: Lack of cycle greater than six months during breastfeeding should be answered as YES.

If YES, total number of months: _____months

Reason(s) for missing your cycle: _____

Do you have any history of infertility? (Circle one) YES/NO

If YES, Treatment(s) received for infertility: _____

Number of Full term Pregnancies: _____Did you breastfeed any of your children? (Circle one) YES/NO

If YES, Number of children breastfed: _____ Total number of months of breastfeeding for all children: _____

Age at birth of first child: _____ Age at birth of last child: _____

Are you postmenopausal (If perimenopausal, has it been more than 12 months without a period)? (Circle one) YES/NO

If YES, date of last period: _____ (MM/YY) Type of Menopause: (Circle one) Natural/Surgical/Chemical (HRT)

Have you taken estrogen and/or progesterone since menopause? (Circle one) YES/NO

If YES, name of medication(s): Month/Year Initiated Month/Year Stopped

_____

(If there are more medications, please list them at the end of this questionnaire.)

Have you had a hysterectomy (removal of uterus)? (Circle one) YES/NO

If YES, date of hysterectomy (Month/Year):_____/_____ Age at the time of hysterectomy: _____ yrs.

Have you had your ovaries removed? (Circle one) YES/NO

If YES, number of ovaries removed? (Circle one) One ovary/Both ovaries

Date(s) of ovary removal(s) (Month/Year):_____/_____ Age at the time of Left ovary removal: _____ yrs.

_____/_____ Age at the time of Right ovary removal: _____ yrs.

Have/had you taken birth control pills or other forms of estrogen prior to menopause? (Circle one) YES/NO

PHYSICAL ACTIVITY

Do you currently exercise on a fairly regular basis? (Circle one) YES/NO

If YES, average number of times you exercise per week (One number): _____

If NO, Do you exercise on a seasonal basis? (Circle one) YES/NO

If YES, How many months per year do you exercise? (One number): _____

Please check mark the type of exercise and length of time you performed this type of exercise.

Type of Exercise	Duration (years)
☐ Baseball, softball, hockey	
☐ Tennis, ping pong, racquetball	
☐ Basketball, volleyball	
☐ Football, soccer, hockey	
☐ Gymnastics, aerobics, dancing, martial arts	
☐ Weightlifting, body building	
☐ Swimming	
☐ Jogging, running	
☐ Walking for exercise	
☐ Skating, snowboarding	
☐ Bicycling, spinning	
☐ Canoeing, kayaking	
☐ Hiking, climbing	
☐ Yoga, Pilates	
☐ Others: _____	

Do you receive at least 15 minutes of exposure to sun per day on the average? (Circle one) YES/NO

TOBACCO USE

Do/did you smoke cigarettes? - Past history or current use of tobacco should be YES. (Circle one) YES/NO

If YES, how old were you when you began smoking cigarettes? _____

What is/was the number of cigarettes smoked per day on the average? (One number): _____

What was the highest number of cigarettes per day you ever smoked? _____

If you no longer smoke cigarettes, at what age did you quit? (One number): _____

Nicotine Dependence Questionnaire

(Based on Fagerström Test for Nicotine Dependence; Copyright permission obtained from Dr. Karl Fagerström 3/17/09 for LOS use)

Please check one answer for each question.

1. How many cigarettes a day do you usually smoke?
[ ] 1 – 10 [ ] 11 – 20 [ ] 21 – 30 [ ] 31 or more

2. What type do you smoke?
[ ] Low nicotine (0.9 mg or less) [ ] Medium nicotine (1.0 – 1.2 mg) [ ] High nicotine (1.3 mg or more)

3. How often do you inhale the smoke from your cigarette?
[ ] Never [ ] Sometimes [ ] Always

4. How soon after you wake up do you smoke your first cigarette?
[ ] Within less than 5 minutes [ ] Within 6-30 minutes [ ] Within 31-60 minutes

5. Do you smoke more during the first two hours of the day than during the rest of the day?
[ ] No [ ] Yes

6. Which cigarette would you most hate to give up?
[ ] The first cigarette in the morning [ ] Any cigarette other than the first one

7. Do you find it difficult to refrain from smoking in places where it is forbidden, such as public buildings, on airplanes or at work?
[ ] No [ ] Yes

8. Do you still smoke even when you are so ill that you are in bed most of the day?
[ ] No [ ] Yes

ALCOHOL USE

Do/did you drink alcohol? Past history or current use of alcohol should be YES. (Circle one) YES/NO

Do you have a history of alcoholism or a drinking problem? (Circle one) YES/NO

	YES	NO	How Much and How Often
Do you drink beer? (Including wine coolers, malt liquor, etc…)	___	___	How many cans or bottles per Day or Week? _____ per _____ (1 can/bottle=8-12 ounces of beverage)
Do you drink wine? (Including sherry, champagne, etc…)	___	___	How many glasses per Day or Week? _____ per _____ (1 glass=6 ounces)
Do you drink liquor? (Including vodka, tequila, whiskey, rum, etc…)	___	___	How many Ounces per Day or Week? _____ Ounces per _____ (1 shot in a mixed drink = 1.5 ounces)

DIET

	YES	NO	How Much and How Often
Do you drink milk? (Including fortified soy, rice, almond milks, etc…)	___	___	How many Cups per Day or Week? _____ Cups per _____ (8 ounce cup)
Do you eat yogurt? (NOT frozen yogurt)	___	___	How many Ounces per Day or Week? _____ Ounces per _____ (Container of yogurt = 4 to 8 ounces; **Please check container for amount.**)
Do you eat cheese?	___	___	How many Ounces per Day or Week? _____ Ounces per _____ (1 square inch of cheese = 1 ounce; 1 slice Kraft Singles = 1 ounce)

NUMBER OF FALLS

How many times do you fall per year on average where you could break a bone (including nearly breaking a bone and actually breaking a bone)? _____

MEDICAL HISTORY

Please list all surgeries with month and year performed (If there are more, please list them at the end of this questionnaire.):

Surgery	MONTH/YEAR of Surgery

Please list all previous fractures or broken bones:

	Location	Date	Cause of Fracture/Incident Details
☐	Skull		
☐	Spine		
☐	Trunk, except spine		
☐	Wrist		
☐	Upper limb, except wrist		
☐	Pelvis		
☐	Hip		
☐	Lower limb, except hip		
☐	Others: _____		

Please indicate whether you have ever experienced the following and whether it is a current condition:

YES	NO	CURRENT	
___	___	___	Serious Residuals from Stroke
___	___	___	Diabetes (insulin dependent)
___	___	___	Thyroid Disease
___	___	___	Asthma
___	___	___	Chronic or Recurrent Lung Disease (e.g. Emphysema, Cystic Fibrosis)
___	___	___	COPD (chronic obstructive pulmonary disease)
___	___	___	Cancer (Not Including Basal Cell or Squamous Cell Skin Cancer)
___	___	___	Colon or Digestive Disorders (e.g. Crohn's Disease, Celiac Disease, Lactose Intolerance)
___	___	___	Ulcers of the Stomach or Intestine
___	___	___	Liver Disease, Hepatitis or Jaundice
___	___	___	Gallbladder or Pancreatic Disease
___	___	___	Kidney Disease
___	___	___	Kidney Stones
___	___	___	Convulsions or Seizure Disorders
___	___	___	Arthritic Pain (e.g. Rheumatoid Arthritis or Osteoarthritis)
___	___	___	Joint Pain (undiagnosed)
___	___	___	Skin Problems (except pigment issues)
___	___	___	Musculoskeletal Disorders (e.g. Multiple Sclerosis, Bone Disease)
___	___	___	Eating Disorders
___	___	___	Alcohol or Drug Problems
___	___	___	Autoimmune or autoimmune-related diseases (e.g. Systemic Lupus Erythematosus, Multiple Sclerosis, Graves' Disease, Hashimoto's Thryroiditis, Myasthenia Gravis, Addison's Disease, Dermatomyositis, Sjögren's Syndrome, Reiter's Syndrome, Splenectomy or others)
___	___	___	Immune-deficiency Conditions (Severe Malnutrition, Ataxia-telangiectasia, DiGeorge Syndrome, Chediak-Higashi Syndrome, Job Syndrome, Leukocyte Adhesion Defects, Panhypogammaglobulinemia, Selective Deficiency of IgA, Combined Immunodeficiency Disease,

Wiskott-Aldrich Syndrome or others)

___ ___ ___ Hematopoietic and Lymphoreticular Malignancies (Leukemias, Hodgkin's Disease, Non-Hodgkin's Disease, Myeloma, Waldenström's Macroglobulinaemia, Heavy Chain Disease, Leukemic Reticuloendotheliosis, Mastocytosis, Malignant Histiocytosis or others)

Please check Medication(s) and Supplement(s) you routinely take each day and complete the corresponding blank lines:

Name of Medication/Supplement	Dosage	Frequency	Mon./Yr. Initiated
☐ Calcium			
☐ Vitamin D			
☐ Multivitamin			
☐ Breathing inhalers, nasal sprays, cortisone			
☐ Hormone replacement therapy			
☐ Testosterone			
☐ Bisphosphonate			
☐ Calcitonin			
☐ Fluoride			
☐ Strontium			
☐ Gonadotropin releasing antagonists (lupron)			
☐ Selective estrogen receptor modulators, such as raloxifene and toremifene			
☐ Anabolic steroids and other androgens, such as dehydroepiandrosterone			
☐ Cyclosporine			
☐ Methotrexate			
☐ Tacrolimus			
☐ Parathyroid hormone			
☐ Anticonvulsant drugs			
☐ Anti-epileptic drugs			
☐ Others: _____			

Please include prescription, over the counter medications/supplements, and herbs in all forms. (If there are more, please list them at the end of this questionnaire. Be sure to include dosage, frequency, and month/year initiated.)

Have you experienced periods of bed rest or limited physical activity lasting 90 days or longer? (Circle one) YES/NO

If YES, please check the reason(s) for decreased activity with duration below:

Reason	Duration (dd/mm/yy – dd/mm/yy)
☐ Cerebrovascular diseases	
☐ Denervation of muscles of lower limb	
☐ Mental disorder	
☐ Fracture of the lower limbs	
☐ Myasthenia	
☐ Postoperative recovery	
☐ Others: _____	

Study ID:

FAMILY HISTORY

Race/Ethnic Origin of Mother (Circle one or more):

African – American/Black Asian Caucasian/White Hispanic/Latino Native American/Pacific Islander

Other please specify: _____

Race/Ethnic Origin of Father (Circle one or more):

African – American/Black Asian Caucasian/White Hispanic/Latino Native American/Pacific Islander

Other please specify: _____

Have any of your relatives had a diagnosis of osteoporosis/osteopenia/dowager's hump (kyphosis), or lacking that, have any of them sustained osteoporotic bone fracture(s)? Such fractures would typically occur in persons past the age of 50, and would be the result of relatively minor trauma or injury. We are particularly interested in fractures of the wrist, spine, shoulder, ribs, pelvis, collarbone, feet, leg bones, jaw, ankle, and arm(s).

Please list each fracture or condition and the approximate age at the time of its occurrence:

Relative (Indicate maternal or paternal relationship.)	**Location of Fracture(s)/Condition** (Include side of body where applicable.)	**Age at Time of Occurrence(s)**

We thank you very much for taking the time to complete this questionnaire and for your assistance in our research efforts!