Dr. David Hanley Osteoporosis Centre
Richmond Road Diagnostic and Treatment Centre
1820 Richmond Road SW, Calgary, AB, T2T 5C7
Phone: 403-955-8050
Fax: 403-476-9626

Dear Patient,

Please complete the attached paperwork, ensuring you complete both the **Health History Form** and the **3 Day Food and Activity Journal**, in preparation for your appointment with the Osteoporosis Specialist. Please send it back to us using one of the following methods:

1. Email: DHOC@albertahealthservices.ca*
2. Fax: 403-355-4302
3. Mail: Dr. David Hanley Osteoporosis Centre

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Please send a scanned or pdf version of the forms, do not send photographs or links to online versions of the forms.
Please ensure that your forms are sent in at least 48 hours prior to your appointment.

For further information about our clinic, please refer to our website at https://www.osteoporosiscalgary.com/

**Please note that we cannot guarantee that emails won't be intercepted by outside entities and we are not responsible for misdirected emails. This email address is used for sending and receiving forms only, other emails sent to this address will be discarded without reply.*

Alberta Health Services

Patient Label

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Health History Form

When complete, please email this form to DHOC@ahs.ca .

Alternatively, it can be mailed or faxed to the address or number at the bottom of this page.

Date Completed:

Patient Information

Patient Name: ______________________ **Phone Number:** ______________________

Health Care Number: ______________________ **Contact Person:** ______________________

Contact Role/Relation: ______________________ **Contact's Phone Number:** ______________________

Family Doctor: ______________________ **Drug Insurance Provider:** ______________________

Pharmacy: ______________________ **Current/Former Occupation:** ______________________

Referral Reason: ______________________

Osteoporosis Education

Have you attended the "Osteoporosis and Bone Health" Class? ☐ Yes ☐ No

If yes, when did you attend the class? ______________________

If no, have you viewed our videos at www.osteoporosiscalgary.com? ☐ Yes ☐ No

Any Comments about the classes/videos? ______________________

History

Please check off all of the following diagnosis you have currently or have been given in the past and note any details you feel we should be aware of.

☐ Blood Clots (Legs, or Lungs)	☐ Kidney Stones
☐ Cancer (specify)	☐ Osteoarthritis
☐ Celiac Disease	☐ Parathyroid Disease (Hyperparathyroidism)
☐ Dementia	☐ Rheumatoid/Inflammatory Arthritis
☐ Diabetes	☐ Seizure Disorder
☐ Gastric Reflux (GERD)	☐ Stroke
☐ Heart Disease	☐ Swallowing problem
☐ High Blood Pressure	☐ Transplant
☐ IBS (Irritable Bowel Syndrome)	☐ Thyroid Disease (hyper, hypo)
☐ IBD (Inflammatory Bowel Disease, Crohn's, Ulcerative Colitis)	☐ Other:
Additional notes:	

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Please answer the questions below to the best of your ability.

Question	Yes	No	Details
Do you partake in any physical activity?	☐ Yes	☐ No	If yes, specify type, frequency and duration:
Had you had any falls in the past year?	☐ Yes	☐ No	If yes, what amount?
Do you use a mobility or walking aid?	☐ Yes	☐ No	If yes, what type of aid?
Do you have back pain?	☐ Yes	☐ No	If yes, where?
Have you become shorter?	☐ Yes	☐ No	If yes, how many inches and what has been your tallest recorded height?
Have you had any Fractures after the age of 40?	☐ Yes	☐ No	If yes, indicate which bones, the year and how it happened:
Have you had any surgery?	☐ Yes	☐ No	If yes, specify the year and procedure:
Do you have any major dental surgery pending?	☐ Yes	☐ No	If yes, please describe:
Have any of your family members broken a hip?	☐ Yes	☐ No	If yes, who and what age were they?
What do you think your current weight is (estimate if you do not have a scale)?			
Have you lost weight recently without trying?	☐ Yes	☐ No	If yes, how much weight have you lost? ☐ 2-11 lbs (1-5kg) ☐ 12-22 lbs (6-10 kg) ☐ 23-33 lbs (11-15 kg) ☐ >33 lb (>15 kg) ☐ Unsure
Have you been eating poorly because of decreased appetite?	☐ Yes	☐ No	If yes, please describe:
Do you ever have difficulty making ends meet at the end of the month?	☐ Yes	☐ No	If yes, please describe:
Females only:			
What was your approximate age when you had your first period?			
What was your approximate age at Menopause (last period)?			
Have you had Hormone Replacement Therapy (HRT)?	☐ Yes	☐ No	If yes, please describe:
Males only:			
What was your approximate age of onset of Puberty?			

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Please mark off whether you have used any of the substances below and note any details to the best of your ability.

Tobacco	(Current Use):	☐ Yes	☐ No	If yes, what type, how much per day and length of use?
	(Past Use):	☐ Yes	☐ No	
Caffeine	(Current Use):	☐ Yes	☐ No	If yes, how many cups per day?
	(Past Use):	☐ Yes	☐ No	
Alcohol	(Current Use):	☐ Yes	☐ No	If yes, how many drinks per week?
	(Past Use):	☐ Yes	☐ No	

Have you ever taken any of the medications below?

Name	Start Date &Stop Date (if applicable)	Reason for Taking and/or Stopping
☐ Etidronate (Didrocal)		
☐ Alendronate (Fosamax)		
☐ Risedronate (Actonel)		
☐ Raloxifene (Evista)		
☐ Pamidronate (Aredia)		
☐ Zolendronate (Aclasta,Zometa)		
☐ Teriparatide, PTH (Forteo)		
☐ Denosumab (Prolia)		
☐ Romosozumab (Evenity)		
☐ Prednisone (for over 3 months)		
☐ Anticonvulsants (for seizures)		
☐ Heparin (injectable blood thinner)		
☐ Chemotherapy		
☐ Diuretics (water pill)		

Are you currently taking any of the supplements below?

Name	Dose & Frequency of Supplements (if known)	Amount in Diet (if known)	Start Date
☐ Calcium (mg/day), please specify: ☐ Carbonate Citrate Other			
☐ Vitamin D (IU/day)			

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Please attach a medication list from your pharmacy or blister pack and/or list all other current medications including over the counter medications, supplements, herbs, vitamins and minerals you are taking.

Name	Start Date	Reason for Taking

Do you have any food or drug allergies or intolerances? Please attach an allergy list if you need more room.

No Known Allergies

Name	Allergy or Intolerance	Reaction/Explanation
	☐ Allergy ☐ Intolerance	
	☐ Allergy ☐ Intolerance	
	☐ Allergy ☐ Intolerance	
	☐ Allergy ☐ Intolerance	
	☐ Allergy ☐ Intolerance	

For Office Use Only

Date: ______________

Height: ______ cm **Blood Pressure: ______mm/Hg**

Weight: ______kg **Pulse: ______**

BMI: ______

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3-Day Food and Activity Journal

Use this journal as a tool to help you meet your eating goals. When you review your journal, you can see the progress you've made, or you may decide to make new goals. Please see the other side for instructions about how to use this food journal.

Meal	Day 1: ___________	Day 2: ___________	Day 3: ___________
Breakfast (First Meal)			
Snack			
Lunch (Second Meal)			
Snack			
Dinner (Third Meal)			
Snack			
Activity			

Developed by Registered Dietitians

Nutrition Services

Alberta Health Services

404204-NFS

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How to fill in this journal

- ❑ Write down everything you eat and drink. You may want to record **one weekday (**or **workday)** and **one Saturday** or **Sunday (**or **day off)**.
- ❑ Include:
  - How much food you ate. See the suggestions below to estimate portion sizes. If the food comes in a package, just write down the package size. Example: 175 mL container of yogurt.
  - How the food is cooked (for example: fried, baked, boiled, barbecued)
  - Anything you add to food, during or after cooking. Example: cream, sugar, oil, butter, jam, syrup, ketchup or other sauces, dressings or condiments.
  - Details about restaurant foods, fast foods, or packaged foods (for example: McDonald's Big Mac® or KFC® chicken).
- ❑ Measure the food you eat for a day or two to help you understand how much you eat and drink. Use measuring cups and spoons.
- ❑ Write down all your **activities** for the day. Include planned activities (going for a walk or swim) and activities of daily life (housework or grocery shopping). Comments may include where you ate, your mood, or stress level.
- ❑ Use more paper if you need to or photocopy the other side of this handout.
- ❑ Read over your journals to see what is working well and what you may want to change.
- ❑ Keep on tracking. Use this tool to help you meet your goals, or to make new goals.

To estimate portion sizes, use the guidelines below:

This amount of food:	**…is about the same size as:**
2½ oz (75g) of meat	a hockey puck
1½ oz (50 g) of cheese	2 white erasers
1 cup (250 mL)	a baseball or fist
½ cup (125 mL)	a hockey puck
1 medium piece of fruit	a tennis ball
2 Tbsp (30 mL)	1 golf ball
¼ cup (60 mL)	2 golf balls
1 tsp (5 mL) – use for butter, margarine, mayonnaise	a thumb tip or one die

Example of how to fill in your food journal:

Meal	Day 1: Thursday	Day 2: Saturday
Breakfast (First Meal)	1 cup Bran Flakes® with 1 tsp sugar and ½ cup 1% milk 1 cup coffee black 1 slice whole wheat toast with 2 tsp soft margarine	1 egg fried in 1 tsp butter with 3 strips of bacon 2 slices whole wheat toast with 2 tsp soft margarine 2 cups tea (chamomile)
Snack	1 carrot muffin - Tim Hortons® 1 medium black coffee - Tim Hortons®	1 medium apple
Activity	Stressful day at work	30 minute walk

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