Covenant Health
Misericordia

Misericordia Community Hospital and Health Centre
Rehabilitation Medicine/Physiotherapy Department

Osteoporosis Questionnaire

Please fill out this questionnaire. It will help us to know your condition better and ensure the class sessions meet your needs as much as possible.

Date: _____

Name: _____

Date of birth: _____

AHC: _____

Address: _____

_____

Phone number: _____

Emergency contact person and phone number: _____

When were you diagnosed with osteoporosis?_____

How did you hear about our program at the Misericordia?_____

Virtual class:

Do you have the following technology and equipment:

___ Internet

___ Email account. Address: _____

___ Device capable of running Zoom platform, with audio and video

Risk Factors for Osteoporosis

Please check (√) any of the following that apply to you

___ Over 50 years old
___ Female
___ Post-menopausal
___ Family history of osteoporosis
___ Thin, with small bones
___ Ovaries surgically removed or menopause reached before age 45
___ Low intake of calcium throughout life
___ Little or no regular exercise
___ Overactive thyroid
___ Smoker or ex-smoker
___ Heavy alcohol user
___ Regular use of steroid or anti-seizure medications
___ Fall(s) within the past year
___ Previous fractures If yes, what part of body?_____

General Health

Do you have any of the following conditions? Please check (√)

___ Allergies (list): _____
___ Arthritis If yes which type:_____ If yes, affected joints:_____
___ Cancer
___ Diabetes
___ Epilepsy
___ Heart problems (including a pacemaker). If yes, does this affect your ability to exercise?
___ High blood pressure
___ Lung problems (Do you have a history of asthma or emphysema?)
___ Previous sprains or fractures. Location: _____
___ Previous surgery. If yes, type:_____
___ Swelling of the lower extremities

Do you have any other health problems? Please explain.

_____

_____

_____

Are you presently receiving treatment or therapy for any condition?_____

If yes, please explain:

_____

_____

_____

Present Symptoms

Have you noticed any of the following symptoms? Please check (√)

___ Dizziness
___ Loss of balance
___ Tingling in the hands
___ Tingling in the feet
___ Changes in walking ability
___ Problems with incontinence (i.e. bladder control such as when coughing or sneezing)
___ Other changes in bladder/bowel function
___ Weight loss without dieting
___ Changes in height. If yes, how much:_____
___ Heart and chest pains

Medication:

Please list all medications, including over the counter medications (non-prescription)

_____
_____
_____
_____
_____
_____
_____
_____

Present Activity Level

How often do you walk? _____
How far do you walk? _____
Where do you walk? _____
Do you presently do any exercises other than walking? If yes, please describe:

_____

_____

_____

Goal for the Osteoporosis Program

What are your reasons for coming to our osteoporosis program? What would you like to get out of the program?

_____

_____

_____