

Quit Smoking? Yes No

How many caffeinated drinks do you drink per day? _____

Have you reached menopause?
At what age did you reach
menopause? _____ Yes No

Have you had a hysterectomy?
Date? _____ Yes No

Have both of your ovaries been removed?
Date? _____ Yes No

Have you ever taken birth control pills?
How long? _____ Yes No

Do you exercise regularly?
How many days per week? _____
How long per day? _____ Yes No

Have you ever used steroid drugs?
How long? _____ Yes No

Have you ever used any inhaled steroids?
What kind of inhaler? _____
How long? _____ Yes No

Have you ever taken thyroid medications?
Which medication? _____
How long? _____ Yes No

Are you allergic to any medications?
What? _____ Yes No

Have you ever been diagnosed with
hyperparathyroidism? Yes No

Do you have an elevated calcium level?
Please list ALL current medications: Yes No