CONCORD REPATRIATION GENERAL HOSPITAL

Department of Endocrinology and Metabolism

**Minimal Trauma Fracture Clinic**

**BASELINE ASSESSMENT**

Date of visit: Investigator: Date questionnaire completed: \_\_ \_\_ \_\_\_\_\_\_

MRN: Patient Initials: DOB: \_\_ \_\_\_ \_\_\_\_\_\_ Age: \_\_\_\_ years

Gender

* Female (01)
* Male (02)

Ethnicity

* Caucasian (European, Mediterranean, Middle Eastern) (01)
* South Asian (Indian, Sri Lankan, Bangledeshi, Pakistani) (02)
* East/Southeast Asian (Burmese, Chinese, Japanese, Korean, Mongolian, Vietnamese) (03)
* Aboriginal & Torres Strait Islander (04)
* African (05)
* Other (06)
* If Other , Please state \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your main form of residence?

* Home (01)
* Hostel (02)
* Nursing home (03)
* Other (04)

Who do you live with?

* Spouse (01)
* Children (02)
* Alone (03)
* Other (04)

What is your source of income?

* Working (01)
* Pension (02)
* Other (03)

What is your highest level of education?

* None (01)
* Primary (02)
* Secondary (03)
* Tertiary (04)
* Other (05)

**FAMILY HISTORY**

Did your mother or father have osteoporosis? (Condition where bones become fragile)

* Yes (01)
* No (02)
* Unknown(03)

Did your mother have a hip fracture?

* Yes (01)
* No (02)
* Unknown (03)

**YOUR MEDICAL HISTORY**

Do you, or have you experienced any of the following? (tick more than one when required)

* None (01)
* Thyroid disease (02)
* Parathyroid disease (03)
* Kidney problems (04)
* Cushings Disease (Disease where you have high cortisone) (05)
* Pagets disease of the bone (06)
* Breathing difficulties (07)
* Ulcers/Gut problems (08)
* Heartburn (09)
* Lactose intolerance (10)
* Coeliac disease (11)
* Low energy levels (12)
* Decline in libido (13)
* Rheumatoid arthritis (14)
* Cancer (15)
* Other (16)

Please provide details in the table below of any medication you have taken.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication** | **Dose** |  | **Start date** |  | **DOCTORS USE ONLY: DISEASE**  **CODE** |
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**YOUR FRACTURE HISTORY**

# What was the mechanism of your recent fracture?

* Fall from standing height (01)
* Spontaneous (02)
* Unknown (03)

##### Which department was your primary care team for the above fracture?

##### Emergency department (01)

##### Endocrinology (02)

##### Geriatrics (03)

##### Orthogeriatrics (04)

##### Orthopaedics (05)

##### Rheumatology (06)

##### Other (07)

Please provide details of any other **past fractures** in the table below.

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| --- | --- | --- | --- | --- | --- |
| **Date of fracture/Age** | **Fracture site** | **Minimal trauma (Y/N)\*** | **Description of cause** |  | **DR’s USE ONLY: FRACTURE**  **CODE** |
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\*Minimal trauma is defined as a fall from a standing height or any milder injury

**FEMALE PATIENTS ONLY**

At what age did you have your first period?

Have you experienced menopause?

* Yes (01)
* No (02)

If yes, at what age?

Have you had a hysterectomy?

* Yes (01)
* No (02)

If yes, at what age?

Did your period ever pause for more than 6 months? (except during pregnancy)

* Yes (01)
* No (02)

Have you been on hormone replacement therapy?

* Yes (01)
* No (02)

If yes, at what was the name of HRT and what age was HRT started and stopped?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **YOUR FALLS RISK**

Have you had any previous falls?

* Yes (01)
* No (02)

Do you suffer from any of the following conditions which may increase your risk of fall? Please tick more than one when required.

* Weakness or loss of feeling in any limb (01)
* Epilepsy (02)
* Bladder problems (03)
* Sleep problems (04)
* Use of sedation or strong pain killers (05)
* Low blood pressure (06)
* Vision impairment (07)
* Dementia (08)

Do you or have you experienced any weakness or loss of feeling in any limb?

* None (01)
* Arm (02)
* Leg (03)
* Foot (04)

Do you use any form of walking assistance?

* None (01)
* Walking stick (02)
* Walking frame (03)
* Support (04)

What do **you think** your self assessed risk of falling is? Please tick one box

* Low (01)
* Medium (02)
* High (03)

**YOUR LIFESTYLE**

# Dietary calcium intake

Please provide approximate quantities or frequencies and circle the appropriate option

1. How many cups of milk would you have per week? 0 2 4 6 8 10 12 14+
2. How many times would you have cereal and milk per week? 0 1 2 3 4 5 6 7+
3. How many slices of cheese do you eat per week? 0 1 2 3 4 5 6 7+
4. How many tubs of yoghurt do you eat per week? 0 1 2 3 4 5 6 7+
5. How many cups of soft drink would you drink per week? 0 2 4 6 8 10 12 14+

DOCTORS USE ONLY

Add the scores from questions 1-5 to give total TOTAL=

# Alcohol intake

How would you describe your alcohol intake?

* Never drank (01)
* Former drinker (02)
* Current drinker (03)

If you are a current drinker, how many standard drinks per day would you have?

* 0-2 (01)
* 2-4 (02)
* 4-6 (03)
* 6-8 (04)
* 8+ (05)
* **Smoking**

How would you describe your tobacco use?

* Never smoked (01)
* Former smoker (02)
* Current smoker (03)

If you are a current smoker, approximately how many cigarettes would you smoke a day?

# Physical activity (please tick one box only)

Do you undertake regular exercise?

* <1/week (01)
* 1/week (02)
* 2/week (03)
* 3/week (04)
* 4/week (05)
* >4/week (06)

On average how much time would you spend walking per **day**?

* 0-15 minutes (01)
* 15-30 minutes (02)
* 30-45 minutes (03)
* 45-60 minutes (04)
* 60 + minutes (05)

On average how much time would your spend doing other aerobic exercise per **week?** (Eg swimming, cycling, jogging)

* 0-15 minutes (01)
* 15-30 minutes (02)
* 30-45 minutes (03)
* 45-60 minutes (04)
* 60 + minutes (05)

Do you have any condition that hinders you from exercise?

* None (01)
* Joint pain (02)
* Illness (03)
* Fracture (04)
* Other (05)

How long do you estimate your daily sunlight exposure to be?

* 0-15 minutes (01)
* 15-30 minutes (02)
* 30-45 minutes (03)
* 45-60 minutes (04)
* 60 + minutes (05)

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

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