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Calcium Disorder Questionnaire

Patient Name/DOB: _____ Date: _____

Calcium History

Do you have any of the following: ❒ Yes ❒ No then check the box that applies if yes

❒ Throat Spasms/voice change	❒ Muscle Cramps	❒ Hand Spasms	❒ Irritability
❒ Seizures	❒ Involuntary Facial Grimacing	❒ Cataracts	❒ Changes in your Nails
❒ Intestinal Cramps	❒ Mental Clouding/memory defect	❒ Mental Fog	❒ Weight Loss
❒ Depression	❒ Fatigue and weakness	❒ Loss of Appetite	❒ Chronic Constipation
❒ Nausea	❒ Abnormal Digestion	❒ Palpitations	❒ White Skin Patches
❒ Chronic Diarrhea	❒ Frequent Urination	❒ Excessive Thirst	❒ Numbness and tingling
❒ Flank Pain	❒ Bone Pain	❒ Immobilized	❒ Stomach Ulcer
❒ Abdominal Pain	❒ Kidney Problems	❒ Pancreatitis	❒ Frequent Bladder Infections
❒ Kidney Stones	❒ Blood in Urine	❒ Hair Loss	❒ Irregular heart beat
❒ Chronic Fungal Skin Or Nail Infections	❒ Urination in the Middle of the Night	❒ XS urination	❒ urine incontinent

Do you have a **personal** history of any of the following: ❒ Yes ❒ No then check the box that applies if yes

❒ Calcium Disorder	❒ Tuberculosis	❒ Overactive Thyroid	❒ Sarcoidosis
❒ Short Stature	❒ Difficult-to-treat Hypertension	❒ Adrenal Disease	❒ Acromegaly
❒ Bowlegs	❒ Chronic Skin Rash	❒ High calcium from childhood	❒ Bone Fracture
❒ Pheochromocytoma	❒ Thyroid Disorder	❒ Osteopenia	❒ Loss of height
❒ Parathyroid Disorder	❒ Intellectual Disability		❒ Osteoporosis

Do you have **family** history of any of the following: ❒ Yes ❒ No then check the box that applies if yes

❒ High calcium in family	❒ Bowlegs	❒ Intellectual Disability	❒ Seizures
❒ Short Stature	❒ Thyroid Disorder	❒ Osteoporosis	❒ Kidney Stones
❒ Parathyroid Disorder	❒ Low calcium in family		

Does your diet include dairy foods, green leafy vegetables, soy or sardines? ❒ Yes ❒ No circle the one that applies

About how much milk do you drink a day? _____

Do you routinely take laxatives? ❒ Yes ❒ No

Do you routinely use enemas? ❒ Yes ❒ No

Do you routinely take antacids? ❒ Yes ❒ No

Do you routinely use sun block lotions? ❒ Yes ❒ No

Do you routinely try to avoid sunlight exposure? ❒ Yes ❒ No

Do you have a history of any type of cancer? ❒ Yes ❒ No

Have you had neck surgery? ❒ Yes ❒ No

Have you had head or neck radiation therapy? ❒ Yes ❒ No

Do you take any of the following medications: ❒ Yes ❒ No then check the box that applies if yes

❒ Lithium	❒ Hydrochlorothiazide/diuretic	❒ Antiseizure drugs	❒ Multiple Supplements
❒ Excessive Doses of, Calcium, Vitamin D, Vitamin A	❒ Alendronate	❒ low intake of calcium/vitamin	❒ Estrogen