Name: ……………………………………………………

MRN: …………………………

Contact Nr.: …………………………

Age	How old are you (in years)? ¦__¦¦__¦¦__¦
Gender	Are you…? ☐Female or ☐Male
General condition	Do you think you have a lot of diseases? ☐Yes ☐No Number of different drugs daily taken? ¦__¦¦__¦ Do you live alone? ☐Yes ☐No
Nutrition	What is your weight (in kg)? ¦__¦¦__¦¦__¦, ¦__¦ What is your height (in meters)? ¦__¦,¦__¦¦__¦ Do you feel malnourished? ☐Yes ☐No
Vision	Do you wear glasses? ☐Yes ☐No
Mood	Do you regularly take psychoactive drugs? ☐Yes ☐No Do you feel sad? ☐Yes ☐No
Cognition	Do you have memory lapses? ☐Yes ☐No
Gait and falls	Did you fall in the previous year (at least one fall)? ☐Yes ☐No Do you usually use a walking aid? ☐Yes ☐No Are you afraid of falling? ☐Yes ☐No
Osteoporosis	Have you already had vertebral fractures? ☐Yes ☐No Do you usually take osteoporotic medications? ☐Yes ☐No

Extra question (1)	Do you currently take Vitamin D tablets/drops or supplements that contain Vitamin D? ☐Yes ☐No

Extra question (2)	Questions are answered mainly by? ☐The patient ☐The relative

Vitamin D level: ………………………… nmol/L.

Thank you 😊