

Osteoporosis Questionnaire

Please provide a list of the medications you are currently taking at the time of this visit.

Name _____ Date of Birth _____

Address _____

Phone number: Home _____ Work _____

Primary Care or Family Physician _____

Address _____

Phone number _____ Fax number _____

1. Gender: Male _____ Female _____
2. Ethnic Background: White _____ African American _____ Asian _____
Hispanic/Latino _____ Other _____
3. Family history of osteoporosis? Yes _____ No _____
4. Do you take a calcium supplement? No _____ If yes, how much daily? _____
5. How many servings of calcium do you obtain through your food daily? _____
6. Do you exercise at least 3 times weekly? No _____ If yes, what type of exercise and for how many minutes in length?

7. Any broken bones during your adult life? (21 years of age or older) If yes, what areas were fractured? _____ No _____

Previous history:

1. Have you ever had a Bone Mineral Density Scan performed? No _____ If yes, where was the scan performed and in what year? _____
2. Have you gone through menopause? No _____ If yes, at what age? _____
3. Have you taken any of the listed medications? Fosamax _____ Actonel _____
Forteo _____ Evista _____ Estrogen _____
Calcitonin _____ Boniva _____
4. Do you have any chance of pregnancy? Yes _____ No _____
5. Have you had a recent barium study or dye study performed in the last two weeks?
Yes _____ No _____
6. Do you have any metal within your body? If yes, explain: _____
7. Any history of the following? If yes, explain:

Thyroid condition _____ Hysterectomy _____

Hyperparathyroidism _____ Blood clots _____

Seizures _____ Low testosterone (males) _____

Steroid use _____ Stomach or colon surgery _____

Cancer _____ DepoLupron injections _____

Pagets Disease _____ Rheumatoid arthritis _____

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Mature height _____ Current height _____ Loss in height _____