Denver Arthritis Clinic

# OSTEOPOROSIS QUESTIONNAIRE

Name: ______________________ Today's Date: ______________________

Date of Birth: ______________ Age: __________

Have you had a DXA before? ______________ Gender: M F

Where / when? ______________ Reason for today's test: ______________

Ethnic Background ______________

Have you fallen in the past year? Yes No

*Were you hurt?* ______________

Do you exercise regularly? Yes No

*How and how often?* ______________

Have you ever smoked? Yes No

*How much?* ______________

*When did you quit?* ______________

How much alcohol do you drink? ______________

Do you eat/drink dairy products? Yes No

*How much?* ______________

Do you take calcium? Yes No

*How much?* ______________

Are you taking vitamin D? Yes No

*How much?* ______________

What was your tallest height? ______________

Have you broken any bones as an adult? Yes No

*Which bones/how/when?* ______________

Have you had back surgery? Yes No

Have you had your hips replaced? Yes No

Do any relatives have osteoporosis? Yes No

*Who?* ______________

Have any relatives broken bones as adults? Yes No

*Who?* ______________

______________

*Which bones?* ______________

**FOR MEN**

Any problems with sexual function? Yes No

Have you had prostate problems? Yes No

*What?* ______________

*How was it treated?* ______________

| Do you have a history of any of the following: | | |
|---|---|---|
| Rheumatoid Arthritis | Yes | No |
| Diabetes Type I Type II | Yes | No |
| Osteogenesis Imperfecta | Yes | No |
| Thyroid Disease | Yes | No |
| Malnutrition or Eating Disorder | Yes | No |
| Intestinal Disorder | Yes | No |
| Liver Disease | Yes | No |
| Parathyroid Disease | Yes | No |
| Kidney Disease/Kidney Stones | Yes | No |

| Have you ever taken the following? | When? |
|---|---|
| Steroids (Prednisone, etc.) | |
| Seizure Medications | |
| *Which one(s)?* | |
| Thyroid Hormone | |
| Etidronate (Didronel) | |
| Alendronate (Fosamax) | |
| Residronate (Actonel) | |
| Nasal Calcitonin (Miacaclin) | |
| Raloxifene (Evista) | |
| Parathyroid Hormone (Forteo) | |
| Pamidronate IV (Aredia) | |
| Zoledronic Acid IV (Zometa, Reclast) | |
| Ibandronate (Boniva) pills | |
| Ibandronate (Boniva) IV | |
| Other osteoporosis treatment: | |

**FOR WOMEN**

Did/do you have irregular menses Yes No

Have you had a hysterectomy Yes No

Were your ovaries removed? Yes No

When did you go through menopause? ______________

Have you ever taken estrogen? Yes No

*When?* ______________

*If discontinued, why?* ______________

Do you have low testosterone (male hormone)?

*Please list any doctors (and addresses) who should receive a copy of this report:*

Referring doctor: ______________________

Others: ______________________

______________________

______________________