

OSTEOPOROSIS QUESTIONNAIRE

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Have you had a DXA before? _____

Gender: M F

When? _____ Where? Hip Spine Heel Wrist

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 low testosterone (male hormone)?

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

Referring doctor: _____

Others: _____

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 (Miacalcin) _____

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? _____