## Osteoporosis Questionnaire

**Name:**

**Today’s Date:**

**Date of Birth:** xx/xx/xxxx  **Age:**

**Gender:** M F

**Have you had a DXA before?**

- **When?**
- **Where?** □ Hip □ Spine □ Heel □ Wrist

**Reason for today’s test:**

**Ethnic Background**

**Do you have a history of any of the following:**

- Rheumatoid Arthritis
  - Yes
  - No

- Diabetes Type I
  - Yes
  - No

- Diabetes Type II
  - Yes
  - No

- Osteogenesis Imperfecta
  - 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?**

- Steroids (Prednisone, etc.)
  - When?

- Seizure Medications
  - *Which one(s)?*
  - When?

- Etidronate (Didronel)
  - When?

- Alendronate (Fosamax)
  - When?

- Residronate (Actonel)
  - When?

- Nasal Calcitonin (Miacalcin)
  - When?

- Raloxifene (Evista)
  - When?

- Parathyroid Hormone (Forteo)
  - When?

- Pamidronate IV (Aredia)
  - When?

- Zoledronic Acid IV (Zometa, Reclast)
  - When?

- Ibandronate (Boniva) pills
  - When?

- Ibandronate (Boniva) IV
  - When?

- Other osteoporosis treatment:
  - When?

**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?**

- Yes
  - No

**Have you ever taken estrogen?**

- Yes
  - No

**If discontinued, why?**

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

- Referring doctor:

- Others:

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