



OSTEOPOROSIS QUESTIONNAIRE

Patient Name: _____ **DOB:** _____ **MRN:** _____

Have you had a Barium X-ray, CT scan or Nuclear Medicine test in the last 2 weeks? Yes ____ No ____
 Are you left or right handed? Left ____ Right ____

- I) WOMEN ONLY:** Age at onset of menstrual periods _____
 Yes/No Were your periods regular?
 Yes/No Did you ever miss periods for longer than 6 months except for pregnancy or menopause?
 Yes/No Have you completed menopause? Age: _____
 Yes/No Have you had a hysterectomy? Age: _____
 Yes/No Have you had one/both ovaries removed? Age: _____

- MEN ONLY:** Yes/No Have you been diagnosed with Testicular Dysfunction?
 Yes/No Have you had Prostate Cancer?

II) CHRONIC CONDITIONS/ILLNESSES (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gastrointestinal problems |
| <input type="checkbox"/> Hyperactive Thyroid | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Chron's Disease |
| <input type="checkbox"/> Hyperactive Parathyroid | <input type="checkbox"/> Uterine Cancer | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Paget's Disease | <input type="checkbox"/> Other Cancer; where _____ | <input type="checkbox"/> Malabsorption |
| <input type="checkbox"/> Hashimoto's Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anorexia/Bulimia |
| <input type="checkbox"/> Cushing's Disease | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Vitamin D Deficiency |
| <input type="checkbox"/> Addison's Disease | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Chronic Kidney Disease |
| <input type="checkbox"/> Asthma or Emphysema | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Back or Hip Surgery |
| | | Specify _____ |

III) HAVE YOU EVER TAKEN ANY OF THE FOLLOWING?

- | | |
|--|---|
| <input type="checkbox"/> Steroids (prednisone) | <input type="checkbox"/> Tamoxifen |
| <input type="checkbox"/> Dilantin/Phenobarbital | <input type="checkbox"/> Testosterone |
| <input type="checkbox"/> Evista | <input type="checkbox"/> PTH (Forteo) |
| <input type="checkbox"/> Actonel or Fosomax | <input type="checkbox"/> Thyroid Medication |
| <input type="checkbox"/> Didronel | <input type="checkbox"/> Heparin |
| <input type="checkbox"/> Miacalcin | |
| <input type="checkbox"/> Hormones (estrogen and/or progesterone) | |

IV) CURRENT MEDICATIONS

(include vitamin D, calcium supplements, Tums, multivitamins)

- _____

V) BONE HISTORY

- Yes/No Ever fractured a bone as an adult? What _____ When _____ How _____
 Yes/No Family history of Osteoporosis?
 Yes/No Family history of hip or other bone fracture from a simple fall or bump?
 Yes/No Have you had back surgery?

VI) OTHER

- Yes/No Do you do regular weight-bearing exercise?
 What? _____ How often? _____
 Yes/No Do you smoke?
 Yes/No Do you drink alcohol? More than 2 drinks per day? Yes/No
 Yes/No Have you ever had a bone density study before?
 Yes/No Have you lost height?