OSTEOPOROSIS QUESTIONNAIRE

Please fill out this questionnaire and bring it with you to your osteoporosis visit.

Name: ____ Age: _______________

Gender: □ Male □ Female If Female, □ Premenopausal □ Postmenopausal

Race/Ethnicity:

□ African American □ Asian □ Caucasian
□ Hispanic □ Indian subcontinent □ Native American/Alaska
□ Native Hawaiian/Pacific Islander □ Other

Height at your tallest: ________________ inches

Current weight: _________________ pounds

Have you ever had a fracture? □ Yes □ No
If yes, where? Age at the time of your fracture?

______________________________ Age: _____
______________________________ Age: _____
______________________________ Age: _____
______________________________ Age: _____

Do you smoke? □ Yes □ No

Did you ever smoke? □ Yes □ No

Do you drink alcohol? □ No □ Yes Amount daily: ____________________

Do you take calcium supplements? □ No □ Yes Amount daily: ____________________

Do you take vitamin D supplements? □ No □ Yes Amount daily: ____________________

Have you ever been on medications for osteoporosis? □ No □ Yes
If yes, what medications? ____

Are you on estrogen or testosterone supplementation? □ Yes □ No

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Please check any medications you are currently taking or have ever taken:

- □ Oral steroids
- □ Radiation therapy
- □ SSRI, SSNI (depression medicine)
- □ Seizure control medicine
- □ Aromatase inhibitors (Tamoxifen)
- □ Lithium
- □ Anticoagulants (heparin)
- □ Methotrexate
- □ Cancer therapy drugs
- □ Proton Pump Inhibitors (stomach medicine)
- □ Thiazolidinediones (TZD) (Diabetes medicine)
- □ Gonadotrophin releasing agonist
- □ Barbiturates
- □ Thyroid hormones
- □ Cyclosporine A and tacrolimus
- □ Parenteral nutrition

Have you fallen? □Yes □No

Does anyone in your family have osteoporosis? □Yes □No

Do you have any of the following medical conditions? (Please indicate with a check)

- □ Diabetes
- □ Celiac disease
- □ Crohn's disease
- □ Anorexia
- □ Lupus
- □ COPD
- □ Muscle weakness
- □ Vision problems
- □ Rheumatoid Arthritis
- □ Gastric bypass
- □ Colitis
- □ Multiple myeloma
- □ Multiple sclerosis
- □ Hypercalciuria
- □ Problems walking
- □ Excessive thinness
- □ Vitamin D deficiency
- □ GI surgery
- □ Malabsorption
- □ Blood disorders
- □ Parkinson's disease
- □ Alcoholism
- □ Balance problems
- □ Kidney disease

Have you had a bone mineral density in the last two years? □Yes □No

Who is your regular health care provider? ____

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