

OSTEOPOROSIS QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

AGE: _____ SEX: MALE / FEMALE HEIGHT: _____ WEIGHT: _____

ETHNICITY: CAUCASION / HISPANIC / AFRICAN-AMERICAN / ASIAN / OTHER

HAVE YOU NOTICED A LOSS IN HEIGHT? YES / NO IF SO, HOW MUCH? _____

WHAT TYPE OF EXERCISE DO YOU DO DAILY? _____

HAVE YOU HAD A BONE DENSITY EVALUATION IN THE PAST? YES / NO

IF SO, WHEN? _____ WHERE? _____

HAVE YOU PREVIOUSLY BEEN DIAGNOSED WITH OSTEOPOROSIS? YES / NO

IF SO, ARE YOU CURRENTLY ON MEDICATION FOR OSTEOPOROSIS? YES / NO

DO YOU SMOKE CIGARETTES? YES / NO HOW MUCH DO YOU SMOKE? _____

DO YOU DRINK ALCOHOL REGULARLY? YES / NO

ARE YOU NOW OR HAVE YOU IN THE PAST TAKEN ANY TYPE OF STEROID MEDICATIONS?
YES / NO

IF SO, HOW LONG HAVE YOU BEEN TAKING OR HOW LONG DID YOU TAKE THESE
MEDICATIONS? _____

ARE YOU NOW OR HAVE YOU IN THE PAST TAKEN ANY ANTI-CONVULSANT MEDICATIONS?
YES / NO

IF SO, HOW LONG HAVE YOU BEEN TAKING OR HOW LONG DID YOU TAKE THESE
MEDICATIONS? _____

DO YOU HAVE A FAMILY HISTORY OF OSTEOPOROSIS? YES / NO

HAVE YOU FRACTURED ANY BONES IN THE PAST? YES / NO

HAVE YOU HAD HIP SURGERY OR LOW BACK SURGERY? YES / NO

WOMEN ONLY:

DATE OF LAST MENSTRUAL CYCLE: _____

IF NO LONGER HAVING MENSTRUAL CYCLE, WAS MENOPAUSE;
NATURAL / SURGICALLY INDUCED. AT WHAT AGE? _____

IF NO LONGER HAVING MENSTRUAL CYCLE, ARE YOU CURRENTLY ON HORMONE REPLACEMENT
THERAPY?

YES / NO