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