LAKESHORE
BONE & JOINT INSTITUTE
ORTHOPEDIC EXCELLENCE. KEEPING YOU IN MOTION.

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