Central Utah Osteoporosis Center

Patient Questionnaire

Name_____ Birthdate__/__/__ Date_____

Phone#: ( )_____ Age:_____ Sex: ❑ F ❑ M Weight_____

Tallest Height:_____ Present Height:_____

Approximate date of last menstrual period:_____

Primary Care Physician:_____ Referring Physician:_____

Circle Yes or No and check the appropriate boxes for the following questions:

RISK FACTORS

1. Race: ❑ White/Caucasian ❑ Black/African American ❑ Asian/Pacific Islander ❑ Other:

2. How many servings of dairy products do you have per week? ❑ 1-3 ❑ 4-9 ❑ 10 or more

2a. Yes No Do you take calcium supplements? Brand:_____ Mg per day:_____

3. Yes No Have you passed through menopause? What age?_____

FEMALE 3a. Yes No Have you had your ovaries surgically removed? When?_____

3b. Yes No Are you currently taking estrogen? How long?_____

MALE 3c. Yes No Do you have low testosterone?

4. Yes No Have you been treated with cortisone, prednisone or similar "steroid-type" drugs in the past?

4a. Yes No Have you ever used inhaled steroids for asthma or had cortisone injections?

5. Yes No Do you have a family history of osteoporosis? Who?

6. Yes No Do you smoke cigarettes?

6a. Yes No Do you have more than 3 alcoholic beverages (including beer) per week?

6b. Yes No Do you regularly have more than 3 caffeine containing drinks per day?

7. Yes No Are you currently taking thyroid hormone medicine?

8. Yes No Have you had a: (please mark the location of the fracture)

❑ wrist fracture when?_____ ❑ caused by a fall

❑ spine fracture when?_____ ❑ caused by a fall

❑ hip fracture when?_____ ❑ caused by a fall

Please see Questions on Reverse Side

ADDITIONAL MEDICAL HISTORY

9. Yes No Have you previously been diagnosed with osteoporosis?

10. Yes No Have you been told that your blood calcium level is high or that you have a parathyroid disorder?

11. Yes No Have you been diagnosed with arthritis or bone disease?

12. Yes No Do you have kidney problems? Kidney stones?

12a. Yes No Are you on dialysis or had a kidney transplant?

13. Yes No Do you have any malabsorption or GI disorders?

14. Yes No Have you had surgery on your back? What type?_____

15. Yes No Have you had surgery on your hip? What type?_____ When?_____

16. Yes No Do you have frequent back pain?

17. Yes No Do you have a curvature of the spine or "dowager's hump"?

18. Yes No Have you ever had breast cancer? ☐ on Tamoxifen ☐ on Arimidex

19. Were you ever on or are you taking:

- ☐ Vitamin D How long?_____
- ☐ Fosamax How long?_____
- ☐ Didronel How long?_____
- ☐ Actonel How long?_____
- ☐ Miacalcin How long?_____
- ☐ Forteo How long?_____
- ☐ Calcium How long?_____
- ☐ Evista How long?_____
- ☐ Boniva How long?_____

Current Medical Problems: _____ _____

_____ _____

_____ _____

_____ _____

Current Medications: _____ _____

_____ _____

_____ _____

_____ _____