

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:
- | | |
|------------------------------------|-----------------|
| <input type="checkbox"/> Vitamin D | How long? _____ |
| <input type="checkbox"/> Fosamax | How long? _____ |
| <input type="checkbox"/> Didronel | How long? _____ |
| <input type="checkbox"/> Actonel | How long? _____ |
| <input type="checkbox"/> Miacalcin | How long? _____ |
| <input type="checkbox"/> Forteo | How long? _____ |
| <input type="checkbox"/> Calcium | How long? _____ |
| <input type="checkbox"/> Evista | How long? _____ |
| <input type="checkbox"/> Boniva | How long? _____ |

Current Medical Problems: _____

Current Medications: _____

