

OSTEOPOROSIS QUESTIONNAIRE

Name: _____ **Birthdate:** _____
Date: _____ **Race:** _____
Chart #: _____ **Height:** _____
Doctor: _____ **Weight:** _____

Completing this form, helps us evaluate your risk for osteoporosis

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Is there a chance that you might be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had a Barium X-Ray or any Nuclear Medicine test within the last two weeks? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a DEXA (Bone) scan?
If yes, When & Where? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you been diagnosed with osteoporosis?
If yes, are you being treated for it?
If yes, How? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have scoliosis (curvature) of the spine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have kyphosis (humpback)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Age of your first menstrual cycle? _____ | | |
| 8. Have you gone through menopause? _____
If yes, What age? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you had a hysterectomy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you take estrogen replacement? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had an organ transplant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you lost any height within the last 2 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you broken any bones within the last 5 years?
If yes, What bone(s)? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you drink caffeinated beverages? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you smoke cigarettes?
If yes, What amount? _____ per day | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you exercise? (circle one) _____ <i>Daily</i> <i>Weekly</i> <i>Not at All</i> | | |

Please list all medication you are currently taking, including any Vitamins or over the counter medicines: _____

Are you allergic to any medicines? If Yes, what?: _____

(OVER)

Name: _____

Date: _____

Chart #: _____

Please Check any of the following that apply to you:

FAMILY INFORMATION

- Family history of osteoporosis
- Family history of arthritis
- Family history of bone fractures

PERSONAL INFORMATION

- Anorexia nervosa (Eating disorder)
- Bulimia (Eating disorder)
- Back pain
- Back Surgery When? _____ Where? _____
- Hip Surgery When? _____ Where? _____
- Breast cancer
- Diabetes
- Disabled/Immobilized
- Epilepsy
- Gastrointestinal disorders
- Thyroid disease/dysfunction
- Kidney disease
- Liver disease
- Rheumatoid arthritis
- Vitamin D deficiency
- Addison's Disease - Endocrine disorder
- Crohn's disease - Inflammation of the gastrointestinal tract
- Cushing disease - Extended high doses of steroids
- Grave's disease - Enlarged thyroid gland, overactive thyroid
- Inflammatory Bowel disease
- Paget's disease - Loss of bone

PLEASE COMPLETE BOTH SIDES OF THIS FORM

I understand that if my insurance company denies this service, I am financially responsible for all charges.

(Patient's signature and date)