ASSOCIATED ENDOCRINOLOGISTS

Osteoporosis questionnaire

Patient Name: _____ Patient Date of Birth: _____

1. What is your ethnicity?
   Caucasian _____ Afro-American _____ Asian _____ American-Indian _____
   Hispanic _____ Polynesian _____ Indian _____ Other _____

2. Have you ever broken any bones? If so, which bones, and at approximately what age: Vertabra (spine) _____ Wrist: Right _____ Left ____ Hip: Right: Right _____ Left ____ Hip Replacement: Right _____ Left ____ Other (please describe): _____	❑ Yes	❑ No	❑ Unknown
3. Do you have Scoliosis?	❑ Yes	❑ No	❑ Unknown
4. Is there osteoporosis in your family? If yes, what relationship to you? _____	❑ Yes	❑ No	❑ Unknown
5. Is there breast cancer in your family?	❑ Yes	❑ No	❑ Unknown
6. What was your maximum height? _____ How tall are you now?_____			
7. When, or at what age did your menopause (last period) occur?			
8. Have you ever been pregnant?	❑ Yes	❑ No	
9. Have you ever had any children? If yes, how many _____	❑ Yes	❑ No	
10. Have you ever taken oral contraceptives? If yes, for how many years _____	❑ Yes	❑ No	
11. Have you taken estrogen therapy post-menopause? (e.g. Premarin, Prempro, Ogen, Estrace, Estraderm, etc) If yes, for how many years: _____	❑ Yes -Now	❑ Yes -Past	❑ No
12. How many servings of dairy products do you consume each day? _____ (one serving = 8 oz. milk, 1 oz. cheese, 1 cup of yogurt / ice cream, 4 oz. cottage cheese) Did you consume three or more dairy servings daily as a teenager and young adult?	❑ Yes	❑ No	❑ Unknown
13. Do you take calcium supplements? If yes, list the name of the supplement, dosage and how often you take it: _____	❑ Yes	❑ No	❑ Unknown
14. Do you take a vitamin D preparation? If yes, list the name of the preparation, dosage and how often you take it: _____	❑ Yes	❑ No	❑ Unknown
15. Do you exercise at least 3 times a week?	❑ Yes	❑ No	❑ Unknown
16. Have you ever smoked? If yes, how many cigarettes a day? _____ How many years did you smoke? _____	❑ Yes	❑ No	❑ Yes, Past

Please be sure to complete both sides of this information form

17. Do you drink alcoholic drinks nearly every day? If yes, how many drinks a day? _____ For how many years? _____	❑ Yes	❑ No	❑ Yes, Past
18. Is your salt (sodium) intake high?	❑ Yes	❑ No	❑ Yes, Past
19. Is your coffee/caffeine intake high? 1-3 cups of coffee / day _____ Above 3 cups / day _____	❑ Yes	❑ No	❑ Yes, Past
20. Is your soft-drink intake high? Less than 12 ounces / day _____ 12 – 36 ounces / day _____ More than 36 ounces / day _____	❑ Yes	❑ No	❑ Yes, Past
21. Have you fallen down frequently?	❑ Yes	❑ No	❑ Yes, Past
22. Do you feel unsteady on your feet?	❑ Yes	❑ No	❑ Yes, Past
23. Have you taken any of the following medications:			
a. Thyroid (e.g. Throxine, Synthroid, Cytomel, Levothroid, Levoxyl, Armour Thyroid)? Name of preparation _____ Dosage & frequency _____	❑ Yes	❑ No	❑ Yes, Past
b. Steroids (e.g. prednisone, Cortisone, etc.)? Name of preparation _____ Dosage & frequency _____	❑ Yes	❑ No	❑ Yes, Past
c. Anticonvulsants (for seizures, epilepsy)? Dilantin _____ Phenobarbitol _____ Other _____ If yes, for how many years _____	❑ Yes	❑ No	❑ Yes, Past
d. Lasix (furosemide), Demadex or Bumax	❑ Yes	❑ No	❑ Yes, Past
e. Thiazide (Hydrodiuril, Hydrochlorothiazide, Dyazide, Maxzide, etc.)	❑ Yes	❑ No	❑ Yes, Past

24. Have you taken any of the following medications for osteoporosis:			
Actonel	❑ Yes	❑ No	How Long _____
Fosamax	❑ Yes	❑ No	How Long _____
Boniva	❑ Yes	❑ No	How Long _____
Evista	❑ Yes	❑ No	How Long _____
Miacalcin	❑ Yes	❑ No	How Long _____
Tymlos	❑ Yes	❑ No	How Long _____
Forteo	❑ Yes	❑ No	How Long _____
Reclast	❑ Yes	❑ No	How Long _____

25. Have you had any of the following conditions:
If so, please circle the letter(s)

a. Partial or complete paralysis (e.g. Stroke, CVA)
b. Hyperthyroidism (over-active thyroid)
c. Kidney stones
d. Kidney disease or failure: If yes, have you ever been on dialysis? ❑ Yes ❑ No
e. Rheumatoid arthritis
f. Hyperparathyroidism (high blood calcium)
g. Liver disease
h. Intestinal (bowel) disease or malabsorption (Crohn's disease, Colitis)
i. Surgical bowel resection or bypass surgery for obesity
j. Pernicious anemia
k. Anorexia nervosa or bulimia
l. Part of stomach removed (ulcer surgery)
m. Breast cancer
n. Hysterectomy
o. Ovaries removed (if yes, at what age? _____)

Please be sure to complete both sides of this information form