OSTEOPOROSIS RISK QUESTIONNAIRE

The risk factors listed below have been identified as contributors to the onset of osteoporosis. Please complete the following questions to the best of your ability. All answers will be kept in strict confidence and treated as information in your medical record.

Your Name _____ Today's Date: _____ / _____ / _____

Date of Birth _____ / _____ / _____ Age _____ Referring Physician _____

Height _____ Weight _____ Please list current medications back of sheet ▶▶

GENERAL INFORMATION

What is your sex? Female O Male O

What is your race?
Caucasian O Afro-American O
Oriental O Other O

	YES	NO
Do you have a fair complexion?	O	O
Do you have a small-boned frame?	O	O

PATIENT MEDICAL HISTORY

	YES	NO
Have you taken any of the following medications or treatments?		
Steroid (prednisone, cortisone etc)	O	O
Thyroid medication	O	O
Anticonvulsants (for seizures)	O	O
Loop diuretics (Lasix, Bumex etc)	O	O
Heparin	O	O
Chemotherapy	O	O
Have you ever had a fractured bone?	O	O
Hip	O	
Spine	O	
Wrist	O	
_____Other	O	
Have you had any of the following conditions or surgeries?		
Over-active thyroid	O	O
Under-active thyroid	O	O
Liver disease or problems	O	O
Kidney disease	O	O
Epilepsy	O	O
Insulin-dependent Diabetes	O	O
Part of stomach removed	O	O
Rheumatoid (or other) arthritis	O	O
Chronic gastrointestinal disorders	O	O
Prolonged immobilization	O	O
Paget's Disease	O	O
Do you have a family history of osteoporosis or other bone disease?	O	O
Do you have relatives who have suffered a broken hip, shoulder, wrist or spine after age 45?	O	O
Have you lost height as you grew older?	O	O

NUTRITION AND EXERCISE

	YES	NO
Do you smoke more the ½ pack of cigarettes a day?	O	O
Have you smoked in the past?	O	O
Is your diet high in animal protein, such as red meat?	O	O
Are you a vegetarian or have a diet heavily consisting of vegetables?	O	O
Do you have an eating disorder, or consume too little nutritious food?	O	O
Do you drink more that 2 alcoholic beverages a day?	O	O
Do you consume less than 3 dairy products a day? (1 serving = 8 oz. milk, 1 oz cheese, container of yogurt or serving of ice cream).	O	O
Do you consume more than 3 cups Of coffee or the equivalent of caffeine from another source such as a cola beverage per day?	O	O
Do you exercise less than 3 times a week or not at all?	O	O
Do you have a lean build or low % of body fat (less than 15% of total body fat?	O	O

PLEASE CONTINUE WITH QUESTIONS ON THE BACK OF THIS SHEET ▶▶ ▶▶

My Current Medications:

Please include dosage

_____

_____

_____

_____

_____

_____

Remaining Questions for Females Only

	YES	NO
Have you gone through the menopause (change of life)?	O	O
Did your menopause occur before the age of 45?	O	O
Do you have amenorrhea (never starting periods, or ended at a young age)?	O	O
Have you had any of the following conditions?		
Hysterectomy (womb removed)	O	O
Ovaries removed	O	O
Blood clots	O	O
If yes, were you on hormones at the time?	O	O
Breast Cancer	O	O
Family history of Breast Cancer	O	O
Cancer of the Uterus (womb)	O	O

	YES	NO
Do you take hormones (Premarin, estrogens, etc)?	O	O
If yes, please list: _____		
_____Started: _____		
Have you taken hormones in the past? (NOT including birth control pills)	O	O
If yes, please list? _____		
From: _____ To: _____		
Have you any of the following side effects from hormones?		
Breast soreness	O	O
Heavy periods or bleeding	O	O
Headaches	O	O
Weight gain or fluid buildup	O	O
Other _____	O	O

PLEASE COMPLETE THE QUESTIONS
ON THE FRONT OF THIS SHEET ▶▶ ▶▶