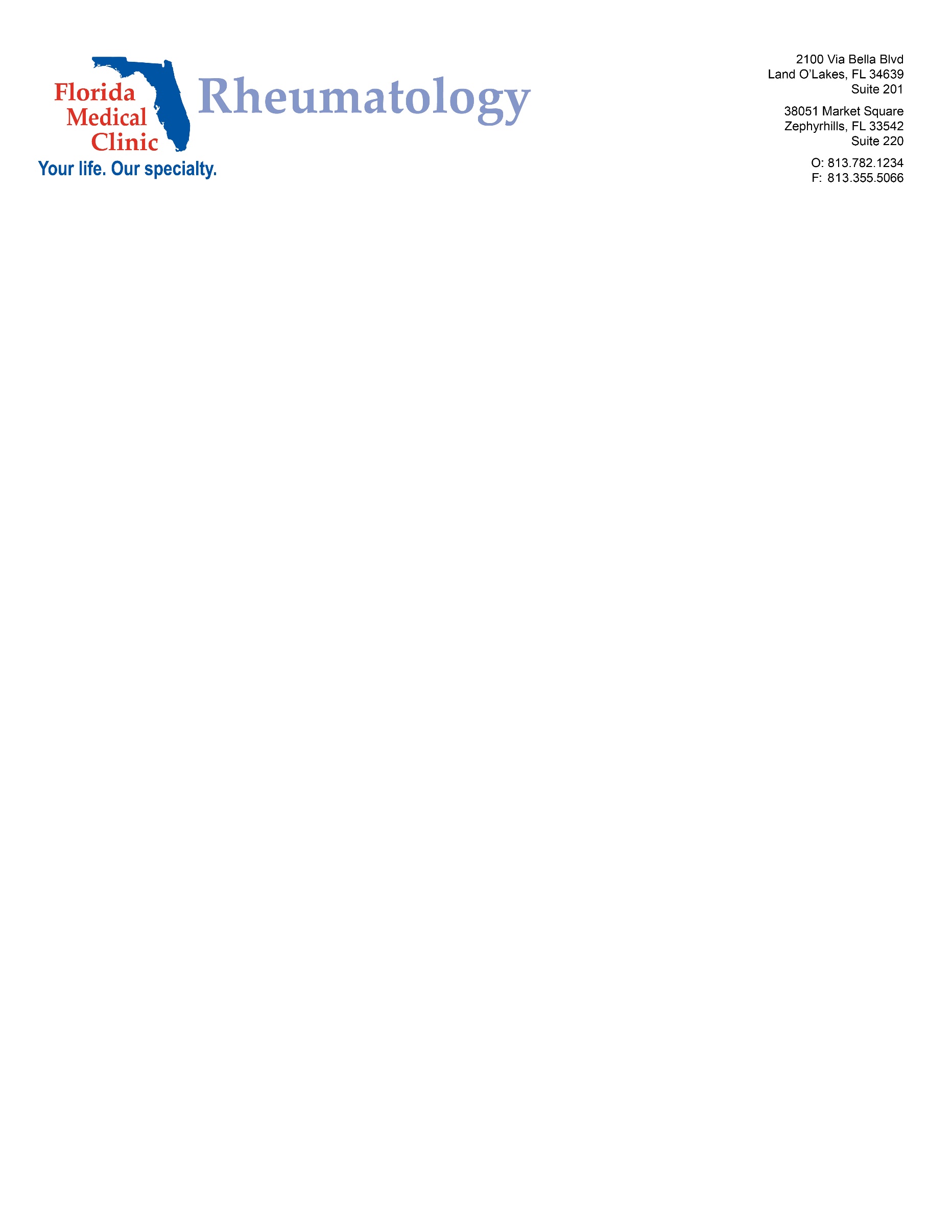
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**Osteoporosis Questionnaire**

|  |  |
| --- | --- |
| Patient Name: | Today’s Date: |
| Patient Date of Birth: Gender: MF | Ethnic Background: |
|  | |
| Have you had a DXA before? YesNo | For which body part? Hip  Spine  Heel  Wrist |
| If so, when? | Reason for today’s test? |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you have a history of any of the following?** | |  | **Have you ever taken the following?** | **When?** |
| Rheumatoid Arthritis | YesNo |  | Steroid (Prednisone, etc.) |  |
| Systemic lupus erythematosus | YesNo |  | Vitamin A |  |
| Diabetes Type I Type II | YesNo |  | Blood Thinner |  |
| Osteogenesis Imperfecta | YesNo |  | Proton pump inhibitor (omeprazole, etc) |  |
| Liver Disease | YesNo |  | Aromatase inhibitor |  |
| Malnutrition or Eating Disorder | YesNo |  | Seizure Medications |  |
| Inflammatory bowel disease | YesNo |  | Antidepressants - *Which one (s)?* |  |
| Gastric Bypass | YesNo |  | Thyroid Hormone |  |
| Celiac Disease | YesNo |  | Etidronate (Didronel) |  |
| Thyroid Disease | YesNo |  | Alendronate (Fosamax) |  |
| Parathyroid Disease | YesNo |  | Residronate (Actonel) |  |
| Cystic Fibrosis | YesNo |  | Nasal Calcitonin (Miacaclin) |  |
| Hemochromatosis | YesNo |  | Raloxifene (Evista) |  |
| Blood Disorder | YesNo |  | Parathyroid Hormone (Forteo) |  |
| Kidney Disease/Kidney Stones | YesNo |  | Pamidronate IV (Aredia) |  |
| Radiation therapy | YesNo |  | Zoledronic Acid IV (Zometa, Reclast) |  |
| Cancer | YesNo |  | Ibandronate (Boniva) pills |  |
| Barrett’s esophagus | YesNo |  | Ibandronate (Boniva) IV |  |
|  |  |  | Denosumab (Prolia) |  |
|  |  |  | Abaloparatide (Tymlos) |  |
|  |  |  | Evenity(Romosuzumab) |  |
|  |  |  | Other Osteoporosis treatment |  |

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you fallen in the past year? | YesNo | Were you hurt? | | |
| Do you exercise regularly? | YesNo | How and how often? | | |
| Have you ever smoked? | YesNo | How much? When did you quit? | | |
| Do you drink alcohol? | YesNo | How much alcohol do you drink? | | |
| Do you eat/drink dairy products? | YesNo | How much? | | |
| Do you take calcium? | YesNo | How much? | | |
| Are you taking vitamin D? | YesNo | How much? | | |
| Have you broken any bones as an adult? | YesNo | Which bones/how/when? | | |
| Have you had back surgery? | YesNo |  | | |
| Have you had your hips replaced? | YesNo |  | | |
| Do any relatives have osteoporosis? | YesNo | Who? | | |
| Have any relative’s broken bones as adults? | YesNo | Who? Which bones? | | |
| What was your tallest height? |  | | | |
|  | | | | |
| **FOR MEN** | |  | **FOR WOMEN** | |
| Any problems with sexual function? | YesNo |  | Did/do you have irregular menses? | YesNo |
| Do you have low testosterone  (male hormone)? | YesNo |  | Have you had a hysterectomy? | YesNo |
| Have you had prostate problems? | YesNo |  | When did you go through menopause? |  |
| What was the problem? | |  | Have you received  Depo-medroxyprogestrerone? | YesNo |
| How was it treated? | |  | Have you taken an aromatase inhibitor? | YesNo |
|  |  |  | Have you ever taken estrogen? | YesNo |
|  |  |  | When? | |
|  |  |  | If discontinued, why? | |

|  |
| --- |
| Referring Doctor’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Please list any doctors (and addresses) who should receive a copy of this report:***  Doctor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Doctor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Others:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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