DIABETES ASSOCIATES MEDICAL GROUP-OSTEOPOROSIS QUESTIONNAIRE

PATIENT NAME: **DOB:**

<u>SYMPTOMS-Describe and circle the correct answer</u>

When were you diagnosed with osteoporosis, what year---------------------------------------
Have you had any bone fracture related to trauma-------------------------------------yes/no?
Have you had any spontaneous bone fracture without any trauma -------------------yes/no?
Have you lost height in inches-----yes/no? How many inches have you lost-----------------
Are you planning dental surgery or tooth extraction----------------------------------- yes/no?
Have you had any bone radiation therapy--- yes/no?
Any frequent falls, dizziness, vision problems, irregular heart beat (circle) ---------yes/no?
Any family history of osteoporosis----yes/no? Any family history of fracture----yes/no?
Have you had any parathyroid surgery or problems-----------------------------------yes/no?
Do you take thyroid medications, steroids, seizure medication, (circle) ------------yes/no?
State the duration in years of use of thyroid medications--------------------------------------
What is your race?----------Are you Caucasian or Asian-------------------------------yes/no?
Do you exercise regularly------yes/no? Type of exercise and frequency----------------------
Do you drink more than 2 cups of coffee, soda or caffeine a day---------------------yes/no?
Do you drink more than 2 alcoholic drinks a day-------------------------------------yes/no?
Do you smoke cigarettes------ yes/no? Did you smoke cigarettes in the past --yes/no?
Do you add salt to foods at the table-- yes/no?
Are you a vegetarian, or have a diet heavily weighted toward vegetables?----------yes/no?
Is your diet high in animal protein, such as red meats? More than 8 oz per day. ---yes/no?
Do you drink milk or take dairy products regularly-----------------------------------yes/no?
Do you take calcium daily-----yes/no? Do you take vitamin D daily---yes/no?
Do you find it difficult taking calcium or vitamin D due to intolerance-------------yes/no?
Do you have low blood calcium--yes/no? Do you have low blood vitamin D------yes/no?
Do you have chronic diarrhea------yes/no? Are you anorexic -----------------yes/no?
Have you been told you have trouble absorbing minerals in the intestines-----------yes/no?
Do you take stomach acid blockers such as Zantac, Prilosec, Tagamet, etc?--------yes/no?
Have you had gastric bypass or intestinal surgery-------------------------------------yes/no?
Any difficulty swallowing-- yes/no? Any stomach ulcer-- yes/no?
Do you have GERD or reflux--yes/no? Do you have Celiac disease----yes/no?
Do you have lactose intolerance or allergy to milk or other dairy products? ----yes/no?
Do you have Rheumatoid arthritis--------yes/no? Do you have Lupus------------yes/no?
Do you have adrenal insufficiency (or Addison's)---yes/no? Cushing's syndrome yes/no?
Do you have kidney stones----------yes/no? Do you have kidney failure------------ yes/no?
Did your menopause occur before age 45------yes/no? Age at menopause-------------------
Did you use estrogens after menopause------yes/no? For how many years----------------
Have you had the ovaries removed yes/no? Do you plan to get pregnant or nurse--yes/no?
For males any history of low testosterone---yes/no?
Please see the section on the website for medication list and fill out the form.