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Osteoporosis Questionnaire

Patient Name/DOB: _____ Date: _____

Osteoporosis History

When were you diagnosed with Osteoporosis? ❒ _____ Or ❒ Never been diagnosed

Have you had any bone fracture due to minor trauma? ❒ Yes ❒ No

Have you had any spontaneous bone fracture without any trauma? ❒ Yes ❒ No

Has your height decreased? ❒ Yes ❒ No If yes, how many inches have you lost? _____ inches

Are you planning on having any dental surgery or tooth extraction in the near future? ❒ Yes ❒ No

Have you had any bone radiation therapy? ❒ Yes ❒ No

Have you had any of the following: ❒ Yes ❒ No then check the box that applies if yes

❒ Frequent Falls ❒ Dizziness ❒ Vision Problems ❒ Irregular Heartbeat

Do you have a family history of Osteoporosis? ❒ Yes ❒ No

Do you have a family history of hip fracture? ❒ Yes ❒ No

Have you ever had any parathyroid surgery or problems relating to your parathyroid? ❒ Yes ❒ No

Do you take any of the following medications, and if so include start date:

❒ Thyroid Replacement Hormone Start Date: _____

❒ Steroids Start Date: _____

❒ Warfarin Start Date: _____

Are you Caucasian or Asian? ❒ Yes ❒ No

- If neither, please specify your race: _____

Do you exercise regularly? ❒ Yes ❒ No

- What type of exercise: _____
- What is the frequency of your exercise regimen: _____

Do you drink more than 2 cups of coffee, soda, or caffeine a day? ❒ Yes ❒ No

Do you drink more than 2 alcohol beverages a day? ❒ Yes ❒ No

Do you currently smoke cigarettes? ❒ Yes ❒ No If no, did you smoke in the past? ❒ Yes ❒ No

Do you often add salt to your food? ❒ Yes ❒ No

Are you vegetarian, or do consume *mostly* vegetables? ❒ Yes ❒ No

Is your diet high in animal protein (such as red meats)? ❒ Yes ❒ No

- Do you consume more than 8oz per day? ❒ Yes ❒ No

Do you drink milk or consume dairy products regularly? ❒ Yes ❒ No

Do you take vitamin D supplements daily? ❒ Yes ❒ No

Do you take calcium supplements daily? ❒ Yes ❒ No

Do you find it difficult taking calcium or vitamin D due to intolerance? ❒ Yes ❒ No

Have you been diagnosed with low blood calcium? ❒ Yes ❒ No

Have you been diagnosed with low blood vitamin D? ❒ Yes ❒ No

Do you have chronic diarrhea? ❒ Yes ❒ No

Are you anorexic? ❒ Yes ❒ No

Have you been diagnosed with having trouble absorbing minerals in your intestines? ❒ Yes ❒ No

Do you take stomach acid blockers (such as Zantac, Prilosec, Tagamet, etc)? ❒ Yes ❒ No

Do you take seizure medications (such as phenytoin, phenobarbital, carbamazepine, primidone ❒ Yes ❒ No

Do you take Pioglitazone or Actos? ❒ Yes ❒ No

Have you had gastric bypass or intestinal surgery? ❒ Yes ❒ No

Do you have any stomach ulcers? ❒ Yes ❒ No

Do you have problems swallowing? ❒ Yes ❒ No

Do you have lactose intolerance/ milk allergy or to other dairy products? ❒ Yes ❒ No

Do you have any of the following:

❒Rheumatoid Arthritis ❒ Cushing's Syndrome ❒ Kidney Failure ❒ Lupus ❒ Kidney Stones

❒ Adrenal Insufficiency ❒ Acid Reflux ❒ Celiac Disease

For Females Only

Did Menopause occur before the age of 45? ❒ Yes ❒ No

At what age did you start menopause:_____

Have you had either of your ovaries removed? ❒ Yes ❒ No

Do you plan to get pregnant or nurse your child? ❒ Yes ❒ No

For Males Only

Do you have a history of low testosterone? ❒ Yes ❒ No