



Office use only

WT _____ HT _____

Female Osteoporosis Questionnaire

Name: _____ Last 4 digits of your SSN #: _____ Date: _____

Date of Birth: _____ Age at Menopause: _____

Referring Physician: _____ Dominant Hand: L R

Instructions: Please CIRCLE the correct answer for each statement or question.

- Y N I have Scoliosis (curvature) of the spine.
- Y N I have metal clips, staples or rods in place from abdominal/spinal surgery.
- Y N I have had hip surgery with metal pins or an artificial hip joint. State side: L R
- Y N I am now pregnant.
- Y N I have had an isotope study (i.e., bone scan/thyroid scan) in the last month.
- Y N I have had a barium enema or barium swallow in the last two weeks.
- Y N I have a family history of osteoporosis or an elderly blood relative that has lost significant height as he/she has aged, or who has developed a "hump" back or "Dowagers" hump.
State relationship: _____
- Y N I have been told that my bone X-rays show **osteoporosis** or **osteopenia**. (circle one)
- Y N I am currently taking medication for osteoporosis/osteopenia.
Name of medication and how long _____
- Y N I have fractured a bone at age 50 or older. Which bone _____ Age at fracture _____
- Y N I have a parent (mother or father) who has fractured a hip.
- Y N I participate in regular exercise. State type and frequency _____
- Y N I currently/used to smoke two packs or more of cigarettes per week.
If quit, what year? _____
- Y N I currently take calcium supplements. _____ Milligrams daily: _____ years/months.
- Y N I have taken a corticosteroid medication (cortisone-like drugs, i.e., prednisone, dexamethasone, etc) for six months or longer. If so from (year _____ to year _____.)
- Y N I have any of the following chronic medical conditions: **Circle all that apply:** Inflammatory arthritis (i.e., Rheumatoid arthritis), insulin dependent diabetes, inflammatory bowel disease, chronic liver or renal (kidney) disease, or a history of having surgical removal of part of my bowel.

- Y N I have taken one or more of the following medications: **Circle all that apply.** Methotrexate, Heparin injections, anticonvulsants (used to combat epilepsy), Lupron depot, chemotherapy for cancer, lithium, thyroid.
- Y N I have been diagnosed with a disease of the parathyroid glands. Please specify:
_____.
- Y N I have lost 1 ½ inches or more in height. What was your full adult height? _____
- Y N Please list all medications and dosages that you are taking, as well as how long you've been taking them: _____

- Y N What is your menopausal status? (check one)
_____ Pre-menopausal _____ Possible early menopause
_____ Going through menopause now _____ Post Menopausal
- Y N Did you undergo a hysterectomy? If so, at what age? _____
- Y N Were your ovaries removed during hysterectomy? If yes:
_____ One _____ Both
- Y N If you have not undergone a hysterectomy, have your ovaries been removed?
If yes, at what age: _____, ovaries _____ one, _____ both.
- Y N Are you currently receiving estrogen replacement therapy? If yes:
What kind: _____ Dosage: _____ For how long: _____
- Y N Have you had breast cancer?
- Y N I drink more than three alcoholic drinks per day.
- Y N My recent intake of dairy products (glass of milk, yogurt, cheese, etc) is less than two servings per day.
- Y N Between childhood and the age of 30, I drank milk on a daily basis.
- Y N I have a history of blood clots of phlebitis.
- Y N I have a history of an eating disorder (i.e., anorexia nervosa, bulimia).
At what age did you begin menstrual periods? _____
- Y N I sometime experience vaginal dryness.
- Y N I sometimes experience hot flashes and/or night sweats.
At what age was your last period? _____
- Y N Do you have a family history of breast cancer? If yes, who? _____
- Y N Do you have a family history of heart disease? If yes, who? _____