

Osteoporosis Survey

Date _____ Patient Name (print) _____

Date of Birth _____ Name of Physician (print) _____

Answer the questions by checking the appropriate response (yes, no, don't know) to the right. If your answer is "yes", enter additional information in box at left.	Yes	No	Don't know
Gynecologic & Bone Densitometry history			
Have you been diagnosed with osteopenia or osteoporosis? If yes, are you currently taking an osteoporosis medication?			
Have you had a bone density exam? (Spine & Hip) If yes, when was your last bone density exam?			
Have you had a hysterectomy? If yes which Year:			
If "yes" were your ovaries also removed?			
Have you entered menopause? If yes, Naturally or Premature < 45?			
Have you experienced irregularity or absence in your menstrual cycle?			
Medications & Medical Background			
• Do you take Seizure medication? (Anticonvulsants – example Dilantin)			
• Have you ever been on hormone replacement therapy? When?			
• Do you or have you taken cortisone, prednisone , or other steroids for treatment of asthma, arthritis, cancer, etc?			
• Kidney problems? (dysfunction, failure, on dialysis or had a transplant)			
• Do you take thyroid medication?			
• Have you been diagnosed with prostate cancer?			
• Are you currently on ADT (Androgen Deprivation) Therapy?			
• Have you experienced a loss in height of at least one inch?			
• Have you ever broken any bones? Year Site How			
Osteoporosis Risk Factors			
Does anyone in your immediate family have osteoporosis? Mother Father Sister(s) Brother(s)			
Do you or have you suffered from an eating disorder?			
Do you weigh less than 127 pounds?			
Do you drink alcoholic beverages & Smoke? Drinks/week & Packs/Day?			

Family Physician _____ Clinic _____

Initial if you would like this information released to your Physician _____

Disease and Drugs Associated with an Increased Risk of Osteoporosis

<input type="checkbox"/>	Diseases	<input type="checkbox"/>	
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Lactose Intolerance
<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	Malabsorption/ Small Bowel Disease
<input type="checkbox"/>	Hypercalcemia	<input type="checkbox"/>	Paget's Disease of the Bone
<input type="checkbox"/>	Hyperparathyroid	<input type="checkbox"/>	Radiation / Chemotherapy
<input type="checkbox"/>	Hyperthyroid, Hypothyroid	<input type="checkbox"/>	Rheumatoid arthritis
<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	Alcoholism
<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	
<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	Medications (How long?)	<input type="checkbox"/>	
<input type="checkbox"/>	Actonel (osteoporosis)	<input type="checkbox"/>	Steroids (Prednisone, etc.)
<input type="checkbox"/>	Fosamax (osteoporosis)	<input type="checkbox"/>	Thyroid Meds. (Synthroid/ Thyroxine)
<input type="checkbox"/>	Anti-Convulsants	<input type="checkbox"/>	Vitamin D (by itself)
<input type="checkbox"/>	Anti-Cancer	<input type="checkbox"/>	Calcium – how many milligrams?
<input type="checkbox"/>	Dilantin	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Diuretics (which one)	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Methotrexate (Rheumatoid Arthritis)	<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	