Office Use Only:
MR#
Date:
HT:
WT:

FEMALE
OSTEOPOROSIS SCREENING QUESTIONNAIRE

Name: ________________________________ Date of birth: _______________ Age: ______ Sex: ______

Ethnicity: Caucasian_______ African American_______ Asian_______ Hispanic_______ Other _______

Referring Physician: ____

- How many servings of the following do you eat or drink per day on average?
  Milk (full cup) ______ Fortified Orange Juice (full cup) _____ Yogurt (small container) _____ Cheese (1oz)_____
- Have you consumed 3 or more dairy servings per day most of your life?……………………………Yes No
- Do you take a daily calcium supplement? If yes, how much? __________mg/day…………………... Yes No
- Is there any chance that you are pregnant?..……………………………………………………………Yes No
- Have you gone through menopause? If yes, at what age? __________…………… ……………….Yes No
- Have you had a hysterectomy? If yes, at what age? _________.…………………………………..…….. Yes No
  - Were both your ovaries removed?………………………………………………………………. .Yes No
- Are you on hormones? If yes, for how long? __________……………………………………………… .Yes No
- If no, have you taken hormones in the past? For how long? __________…………………………....Yes No
- Do you exercise at least three times a week?……..…………………..………………………………..Yes No
  If yes, what type and for how long? ____
- Do you currently smoke?..……………………………………………………………………………..….. Yes No
  If yes, how many packs per day ________ for how many years ________
- Have you smoked in the past?…………………………………………………………………………….Yes No
  If yes, how many packs per day _______ for how many years _______when did you quit? _______
- Do you drink more than two alcoholic drinks per day? If yes, how many? ________………………...Yes No
- How much caffeine do you consume per day? ____
- Do you have osteoporosis?……………………………………………………………………………….…. Yes No
- Do you have a family history of osteoporosis? If yes, what relationship______________……………..Yes No
- Have you ever had a bone density test before? ………………………………………………………….Yes No
  If yes, when and where? ____

(Questions continue on back)

Do you or have you had any of the following conditions?	YES	NO
➢ Uniterine cancer…………………………………………	_____	_____
➢ Breast cancer…………………………………………	_____	_____
➢ Family history of breast cancer…………………………	_____	_____
➢ Amenorrhea (absence of or abnormal stopping of your period)………………	_____	_____
➢ Osteoarthritis…………………………………………	_____	_____
➢ Rheumatoid arthritis…………………………………………	_____	_____
➢ Hyperthyroidism (**over**-active thyroid)……………………………	_____	_____
➢ Hyperparathyroidism or high calcium level in your blood?……………………	_____	_____
➢ Kidney stones or kidney disease………………………………	_____	_____
➢ Gastric bypass (part of stomach removed)…………………………	_____	_____
➢ Crohn's disease or **inflammatory** bowel disease……………………	_____	_____
➢ Gallbladder removed…………………………………………	_____	_____
➢ Blood clots while on hormones…………………………………	_____	_____
➢ Lower back fracture or surgery (if yes explain)__________________________	_____	_____
➢ Hip fracture or surgery (if yes explain)_________________________________	_____	_____
➢ Unexplained weight loss…………………………………………	_____	_____
➢ Pacemaker or implanted Defibrillator………………………………	_____	_____
➢ Within the last two weeks have you had an injection of x-ray dye or ingested barium?……………………………………	_____	_____

Have you ever taken any of the following medications?

- Corticosteroids (Prednisone, Deltasone, etc.)…………………………… ._____ _____
  If yes, for how long? _____________________
- Thyroid medication……………………………………………… .._____ _____
  If yes, for how long? _____________________
- Seizure medication (Dilanton, Depakote, Neurontin)……………………_____ _____
  If yes, for how long? _____________________
- Heparin (a blood thinner)……………………………………… .._____ _____
  If yes, for how long? _____________________

List your current prescription and over the counter medications:

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List any chronic (long-term) medical conditions:

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revised 01/08