

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

MALE 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
- Have you had an orchiectomy (testicles removed)?.....Yes No
- Have you had a prostatectomy (prostate removed)?.....Yes No
 - Surgery, radiation, hormones?.....Yes No
- Are you on hormone therapy for prostate cancer? If yes, 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? _____

Do you or have you had any of the following conditions?

YES NO

- 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)..... _____
- Crohns 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? _____
- Testosterone (shots, pills, or gel)..... _____
If yes, for how long? _____
- Hormone therapy for prostate cancer (Lupron, Zoladex, etc.)..... _____

List your current prescription and over the counter medications:

List any chronic (long-term) medical conditions:
