PATIENT QUESTIONNAIRE

NAME: _____ **DATE** _____

PRIMARY MD: _____

Do you want a copy to be sent to primary MD? ____

1. Is there a chance you may be pregnant? Yes ___ No ___
2. Have you had a barium x-ray in the last 2 weeks? Yes ___ No ___
3. Have you had a nuclear medicine scan or injection of an x-ray dye in the last week? Yes ___ No ___
4. Ethnicity: Caucasian (white) ___ Black ___ Asian ___ Hispanic ___ Other ___
5. Have you ever had a Bone Density Test? Yes ___ No ___
   If yes, where was it done? _____
6. Your tallest height (late teens or young adult) _____
7. Have you ever broken a bone? Yes ___ No ___
   If yes, which bone did you break? _____ How did you break it? _____
   At what age did you break it? _____
   (A previous fracture denotes more accurately a fracture in adult life occurring spontaneously or a fracture arising from trauma, which in a healthy individual, would not have resulted in fracture.)
8. Do you have a family history of osteoporosis? Yes ___ No ___
9. Has a parent or sibling had a broken hip from a simple fall or bump? Yes ___ No ___
10. Has a parent or sibling had any other type of broken bone from a simple fall or bump? Yes ___ No ___
11. How many times have you fallen during the last year? _____
11. Are you currently receiving or have you previously received Prednisone of Cortisone?
    Yes currently ___ Yes previously ___ For how long? _____ What is/was your dose? _____
12. List any chronic medical conditions that you have: _____
    _____
    _____
13. Are you currently receiving or have you previously received any of the following medications?

	No	Yes	For how long?
Medication for seizures or epilepsy			
Chemotherapy for cancer			
Medication to prevent organ transplant rejection			

(Please see and complete other side of questionnaire)

14. Have you been treated with any of the following medications?

	Ever?	Currently?	If currently, for how long?
Hormone replacement therapy (Estrogen)			
Tamoxifen			
Evista (Raloxifene)			
Armidex			
Testosterone			
Fosamax (Alendronate)			
Actonel (Risedronate)			
Boniva (Ibandronate Sodium			
Forteo (PTH)			
Reclast (Zoledronic Acid			

15. How many days a week do you exercise? _____ How long do you exercise each time? _____

    What kind of exercise do you do? _____

    _____

16. How many servings of the following do you eat or drink per day on average?

Serving size	Milk 1 cup	Calcium enriched orange juice 1 cup	Yogurt 1/2 cup	Cheese 1 oz.	Other calcium rich foods 1 cup
Number of servings					

17. Do you take Calcium supplements (including Tums) Yes ___ No ___ How much? _____

18. Do you take a Multivitamin? Yes ___ No ___

19. Do you take a Vitamin D supplement? Yes ___ No ____ How much? _____

20. Do you take Fish Oil? Yes ___ No ___

21. Do you smoke? Yes ___ No ___

22. How much caffeine do you drink each day? _____

23. How much alcohol do you drink each day? _____

24. Are you still having periods? Yes ___ No ___

25. Have you had your menopause? Yes ___ No ___ If yes, how old were you? _____

26. Have you had a hysterectomy? Yes ___ No ___ If yes, how old were you? _____

27. Have you had both of your ovaries removed? Yes ___ No ___