

Osteoporosis Risk Questionnaire

Date: _____

Name: _____ Age: _____ Birthdate: _____

Referring Physician: _____ Height: _____

Risk Factors

Weight: _____

Circle one

- Y N MENOPAUSE YEAR ____ or AGE _____
- Y N HYSTERECTOMY YEAR _____
- Y N ESTROGEN USE YEARS _____
- Y N LOSS OF HEIGHT HOW MUCH _____ inches
- Y N FAMILY HISTORY OF OSTEOPOROSIS or FRACTURE -WHO? _____
- Y N ABNORMAL X-RAYS SHOWING THIN BONES
- Y N STEROID USE DRUG/DURATION _____
- Y N THYROID MEDS DRUG/DURATION _____
- Y N DIURETICS DRUG/DURATION _____
- Y N EXERCISE HOW MUCH/OFTEN _____
- Y N SMOKE _____ PACKS/DAY #OF YEARS _____ QUIT _____
- Y N DRINK ALCOHOL DRINKS PER DAY _____
- Y N DRINK CAFFEINE CUPS PER DAY _____
- Y N HISTORY OF FRACTURES LOCATION/YEAR _____

Current Medications:

_____	_____
_____	_____
_____	_____

Do you take? Dosage?

ESTROGEN	_____
FOSAMAX	_____
EVISTA	_____
FORT'EO	_____
MIACALCIN	_____
CALCIUM	_____
VITAMIN D	_____
ACTONEL	_____

Medical Problems:
