



OSTEOPOROSIS RISK FACTOR SURVEY

Patient Name _____ Date: _____

DOB: _____ Age: _____ Sex: Male Female

Height: _____ Weight: _____

Race: Asian Caucasian African American Hispanic Native American

Please circle answers below:

Do you smoke? Yes No
If yes, how much? _____
If no, did you ever smoke? Yes No
If yes, when did you stop? _____

Do you drink alcohol? Yes No
If yes, how many drinks per day? _____

Do you exercise more or less than 30 minutes daily 3 times per week? More Less

Is your diet low, moderate or high in dairy products and other sources of calcium?
Low Moderate High

Do you take calcium pills? Yes No How many milligrams per day? _____

Do you have a family history of osteoporosis (thinning of the bones)? Yes No

Have you ever broken any bones? Yes No
If yes, which ones? _____

Are you postmenopausal? Yes No
If yes, when did you start menopause? _____

Have you ever had a DEXA bone density scan? Yes No
If yes, when _____ Was it normal? Yes No

Have you ever been told you have the following medical conditions:

Osteoporosis (thinning of the bones)	Yes	No
Hyperparathyroidism	Yes	No
Hyperthyroidism	Yes	No

Have you ever taken any of the following medications for more than one month:

Thyroid replacement medicine	Yes	No
Steroids including inhalers for asthma	Yes	No
Estrogen replacement therapy	Yes	No
Bisphosphonates (Fosamax, Actonel)	Yes	No
Anticonvulsants (such as neurontin, topamax, dilantin, etc)	Yes	No