

ORANGE COAST WOMEN'S MEDICAL GROUP
 24411 Health Center Dr. Suite 200C, Laguna Hills, CA 92653
 949-829-5500

BONE DENSITY QUESTIONNAIRE

Name: Patient ID: Current Height: (in) Weight: (lb) Menopause Age:	Today's Date: Date of Birth: Referring Physician: Ethnicity:
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| 1. Have you had a previous hip or vertebral fracture? | Yes | No |
| 2. Have you had any non-traumatic fractures over the age of 40? | Yes | No |
| 3. Did either of your parents ever have a hip fracture? | Yes Who? | No |
| 4. Is there anyone in your family with osteoporosis? | Yes | No |
| 4. Do you smoke? | Yes | No |
| 5. Have you ever taken Prednisone for 3 months or more? | Yes | No |
| 6. Has a doctor diagnosed you with rheumatoid arthritis? | Yes | No |
| 7. Have you been diagnosed with secondary osteoporosis? | Yes | No |
| 8. Do you drink 3 or more alcoholic drinks per day? | Yes | No |
| 9. Are you being treated for osteoporosis? | Yes | No |

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| 10. Have you EVER taken the following medications?
Actonel (i.e. risedronate)
Evista (i.e. raloxifene)
Fosamax (i.e. alendronate)
Miacalcin (i.e. calcitonin)
Reclast (i.e. zoledronate)
Thyroid medication? | If so, HOW LONG?
Boniva (i.e. ibandronate)
Forteo (i.e. parathyroid)
Protelos (i.e. strontium)
Prolia (i.e. denosumab)
Tamoxife/Femara
Hormone Replacement |
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| 11. Are you currently on the following supplements?
Vitamin D _____ IU Calcium _____ mg | If so, HOW MUCH? |
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| 12. Do you have any of the following conditions?
Anorexia or Bulimia
Asthma or Emphysema
End stage renal disease
Hyperparathyroidism/Hypothyroidism | Any Seizure Disorders
Any Cancer? CHEMO? Y N
Bowel diseases/Colitis
Hysterectomy – Partial or Complete |
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| 13. What was your maximum height (inches)? _____ | |
| 14. Do you perform weight bearing exercise regularly? | Yes No |
| 15. Do you regularly consume dairy products? Yes | MILK, YOGURT, CHEESE Yes No |
| 16. Do you drink caffeinated beverages? Yes | How many cups daily? Yes No |