CONCORD ORTHOPAEDICS

OSTEOPOROSIS QUESTIONAIRE

NAME_____**DOB**_____**DATE**_____

PRIMARY CARE PHYSICIAN_____

ARE YOU PREGNANT?_____
HAVE YOU HAD A NUCLEAR SCAN WITHIN THE LAST FIVE DAYS?_____

DIETARY HISTORY
HAVE YOU CONSUMED THREE OR MORE DAIRY SERVINGS PER DAY FOR MOST OF YOUR LIFE? _____
ARE YOU TAKING A CALCIUM SUPPLEMENT?_____
ARE YOU TAKING VITAMIN D OR A MULTIVITAMIN WITH D?_____

MEDICAL HISTORY
SURGERIES:
THYROID_____
REMOVAL OF UTERUS_____DATE_____
REMOVAL OF OVARIES (ONE) _____ (BOTH) _____DATE_____
HIP OR SPINE_____
OTHER_____

MEDICAL CONDITIONS (CHECK ALL THAT APPLY)
OVERACTIVE THYROID_____ INFLAMMATORY BOWEL DISEASE_____
EATING DISORDER_____ KIDNEY DISEASE_____ OSTEOPOROSIS_____
PARATHYROID DISORDER_____ DIABETES_____RHEUMATOID ARTHRITIS_____
CUSHING'S DISEASE_____ CANCER (TYPE) _____ PAGET'S DISEASE_____

DO YOU HAVE A FAMILY HISTORY OF
OSTEOPOROSIS?_____
HIP FRACTURE?_____

FRACTURES FROM MINIMAL OR NO TRAUMA (CHECK ALL THAT APPLY)
HIP_____ PELVIS_____ FOOT/ANKLE_____ WRIST_____SPINE_____
FINGERS/TOES_____ SHOULDER_____

DO YOU HAVE A PROBLEM WITH
DIZZINESS?_____
FALLS?_____
VISION?_____

PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING OVER THE COUNTER

MEDICINE **DOSAGE**

_____
_____
_____
_____
_____
_____
_____

MEDICATION **DOSAGE**

_____
_____
_____
_____
_____

HAVE YOU EVER TAKEN PREDNISONE OR OTHER STEROID MEDICATIONS? _____
IF YES, HOW LONG? _____

HAVE YOU EVER TAKEN ANTISEIZURE MEDICATION?_____
IF YES, HOW LONG? _____

WOMEN ONLY
HOW OLD WERE YOU AT THE TIME OF YOUR FIRST MENSTRUAL PERIOD? _____
HOW OLD WERE YOU AT THE TIME OF YOUR LAST MENSTRUAL PERIOD?_____
HAVE YOU EVER TAKEN BIRTH CONTROL PILLS? _____
HOW MANY TIMES HAVE YOU BEEN PREGNANT? _____
HAVE YOU EVER TAKEN FEMALE HORMONE REPLACEMENT? _____ IF YES, CURRENTLY? _____ FOR HOW LONG? _____

SOCIAL HISTORY
ARE YOU A SMOKER? _____ PREVIOUSLY? _____ IF YES OR PREVIOUSLY, FOR HOW LONG? _____

DO YOU EXERCISE? _____ WHAT TYPE AND HOW OFTEN?_____
_____
_____
_____

_____

PATIENT SIGNATURE **DATE**