CONCORD ORTHOPAEDICS, P.A.

OSTEOPOROSIS QUESTIONAIRE

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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?___________________________
____
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PATIENT SIGNATURE **DATE**