Arthritis & Osteoporosis Associates
Rheumatology At Its Best

Osteoporosis Questionnaire

Name:____ Date: _______________ SS# (last 4 only):__________

Date of Birth:__________________________ Referring Provider: ______________________________________

Ethnicity: ☐ African American ☐ Caucasian ☐ Asian ☐ Hispanic ☐ Multiracial ☐ Unknown ☐ Other_____

Height:____ Weight:____ Have you noticed a decrease in your height? ☐ No ☐ Yes If yes, how much? ____

Have you previously had a Bone Density (DEXA)? ☐ No ☐ Yes ☐ Check here if last bone density was here at AOA

If at a different facility, please provide name of facility & date of scan: _______________________________

Do you have a family history of Osteoporosis? ☐ No ☐ Yes

Are you on hormone replacements (Estrogens)? ☐ No ☐ Yes If yes, duration?__________________________

Age of menopause? _____________ ☐ Check here if n/a

Have you had your ovaries removed? ☐ No ☐ Yes If yes, age of removal?______________________________

Have you taken any of the following medications in the past ☐ 6 months ☐ one year *(Check all that apply):*

☐ Steroids: Dose___ Duration: _________ ☐ Heparin ☐ Anti-seizure medication ☐ Thyroid hormone replacement meds

Have you taken any of the following osteoporosis medications with the last ☐ 6 months ☐ one year:

☐ Actonel ☐ Boniva ☐ Evenity ☐ Evista ☐ Forteo ☐ Fosamax ☐ Miazalcin ☐ Prolia ☐ Reclast

Do you have a history of any of the following: (*Check all that apply*):

☐ Hyperthyroidism ☐ Hyperparathyroidism ☐ Cushing's Disease ☐ Eating disorder(s) ☐ Ulcer disease

Have you fractured any bones in the past? ☐ No ☐ Yes If yes, when? _________________________________

Have you ever had spine or hip surgery? ☐ No ☐ Yes If yes, which type? ______________________________

Have you had any other surgeries within the past year? ☐ No ☐ Yes If yes, type of surgery? ______________

Do you use tobacco products? ☐ No ☐ Yes If yes, what type/frequency? ______________________________

Do you drink alcohol? ☐ No ☐ Yes If yes, please provide type and frequency. __________________________

Do you drink soda? ☐ No ☐ Yes If yes, amount/frequency? ____

Do you consume a diet low in calcium? ☐ No ☐ Yes Do you take calcium supplements? ☐ No ☐ Yes

Level of Activity/Exercise: ☐ Vigorous ☐ Regular ☐ Occasional ☐ None Type of Exercise: _______________

Please send my results to the following physician: (provide name, address) _____________________________