

Name: _____ Date: _____

Gender: *Female* *Male* Height: _____ Weight: _____

Race (circle one): *Asian* *Black* *White* *Hispanic* *Other:* _____

Have you had a bone density study before? (circle one):

No *Yes, here* *Yes, elsewhere:* Location: _____ Date: _____

Do you have a family history of osteoporosis? Yes No

Do you smoke tobacco? Yes No

Do you drink more than three alcoholic drinks per day? Yes No

Do you exercise regularly? Yes No

Is your diet low in dairy products and other sources of calcium? Yes No

Do you take calcium supplements? Yes No

Are you on hormone replacement therapy now? Yes No

If so, for how many years? _____

Are you taking any medication for osteoporosis? Yes No

Did you ever fracture your hip, spine, or wrist? Yes No

Have you had other fractures since age 50? Yes No

Did either of your parents have a hip fracture? Yes No

Have you had surgery on your hip, spine, or wrist? Yes No

Have you lost more than 1.5 inches of height since high school? Yes No

Do you have hyperparathyroidism? Yes No

Do you have hyperthyroidism? Yes No

Do you have rheumatoid arthritis? Yes No

Do you take thyroid medication regularly? Yes No

Do you take prednisone or other steroids regularly? Yes No

Have you ever been diagnosed with breast cancer? Yes No

7/29/2009

ARE you Post MENOPAUSAL? *Yes* *No*