OSTEOPOROSIS QUESTIONAIRE

NAME:_____DATE:_____DOB:_____

PHYSICIAN:_____PHYS TO READ BONE DENSITY:_____

PREVIOUS BONE DENSITY AT DALLAS DIAGNOSTIC? YES:_____NO:_____

HOW OLD WERE YOU WHEN YOU STARTED MENOPAUSE? AGE_____

HYSTERECTOMY? YES___NO___WHEN?_____
WERE OVARIES ALSO TAKEN? YES___NO___

HAVE YOU TAKEN ESTROGEN PILLS OR PATCHES? (HORMONE THERAPY) YES___NO___FROM_____TO_____

FAMILY HISTORY OF OSTEOPOROSIS? YES___NO___RELATIONSHIP?_____

ARTHRITIS OF SPINE OR HIP? YES___NO___WHICH ONE?_____

PERSONAL HISTORY OF FRACTURES AS AN ADULT? YES___NO___WHICH BONE(S) AND WHEN?____
_____

EXERCISE MORE THAN ONCE A WEEK? YES___NO___HOW OFTEN?_____
TYPE_____

DO YOU TAKE A VITAMIN D SUPPLEMENT? YES___NO___FOR HOW LONG?_____

DO YOU TAKE A CALCIUM SUPPLEMENT? YES__NO__HOW MUCH?_____
FOR HOW LONG_____

OTHER MEDICATION TO TREAT OSTEOPOROSIS? YES__NO__WHICH ONE?_____
FOR HOW LONG?_____

DOES YOUR DIET INCLUDE?

MILK?	YES___NO___AMOUNT?_____
YOGURT?	YES___NO___AMOUNT?_____
CHEESE?	YES___NO___AMOUNT?_____
ICE CREAM?	YES___NO___AMOUNT?_____

IF YOU ARE NOT A PATIENT AT DALLAS DIAGNOSTIC ASSOCIATION PLEASE INDICATE THE MEDICATIONS YOU ARE TAKING?

1._____ 2._____

3._____ 4._____

5._____ 6._____