Katy Rheumatology & Associates, P.A.

Osteoporosis Medical History Questionnaire

Name: _____ Age: _____ Date: _____

Referred By: _____ Gender: M F Scan No: _____

Wt. _____ Ht. _____ Birthdate: _____ Insurance: _____

Ethnic Background: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic

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Why has your referring physician sent you here? _____

Have you lost height? ☐Yes ☐ No

If so, by how many inches? _____

Are you a current smoker? ☐Yes ☐ No

Have you fractured your hip, back, shoulder or wrist as an adult? ☐Yes ☐ No

If so, please describe how the fracture occurred (eg: fall, accident etc.) and at what age?

_____

Have either of your parents fractured a hip? ☐Yes ☐ No

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

Are you currently on a steroid medication (prednisone, cortisone, dexamethasone, solumedrol)? If yes, what dose_____? ☐Yes ☐ No

Have you ever been on 5 mg. per day or higher of prednisone for over 3 months? ☐Yes ☐ No

Do you have a known diagnosis of any of the following:

Rheumatoid Arthritis	☐Yes ☐ No
Untreated hyperthyroidism (overactive thyroid)	☐Yes ☐ No
Early menopause (before age 45)	☐Yes ☐ No
Insulin dependent diabetes (Type I)	☐Yes ☐ No
Chronic liver disease	☐Yes ☐ No
Low testosterone or low estrogen levels	☐Yes ☐ No
Celiac disease	☐Yes ☐ No
Have you had any hip or back surgery?	☐Yes ☐ No
Thyroid disease?	☐Yes ☐ No
Parathyroid disease?	☐Yes ☐ No

Have you had any hip or back surgery? □Yes □ No

Do you have any metal in your prosthetic hip or knee? □Yes □ No

Do you currently consume more than 3 alcoholic beverages a day? □Yes □ No

Have you had any nuclear, barium testing, or diagnostic imaging with contrast recently? □Yes □ No

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Have you had a bone density before? □Yes □ No

If yes, when did you have the bone density. _____

What was the result: □ Normal □ Osteopenia □ Osteoporosis

Have you ever taken any of the following medications?

Thyroid	□Yes	□ No	Prednisone	□Yes	□ No	Miacalcin	□Yes	□ No	Fosamax	□Yes	□ No
Estrogen	□Yes	□ No	Cortisone	□Yes	□ No	Boniva	□Yes	□ No	Dilantin	□Yes	□ No
Actonel	□Yes	□ No	Evista	□Yes	□ No	Forteo	□Yes	□ No	Reclast	□Yes	□ No
Tegretol	□Yes	□ No	Prolia	□Yes	□ No	Atelvia	□Yes	□ No	Progesterone	□Yes	□ No

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What is your total dietary calcium intake per day: _____

Do you take a calcium supplement? If yes, total milligrams per day: _____ □Yes □ No

Does the product contain vitamin D? If yes, amount: _____ □Yes □ No

Are you taking a vitamin D supplement? If yes, amount:_____ □Yes □ No

Are you taking a multi-vitamin? □Yes □ No

Total Vitamin D _____ *Total Calcium* _____

Are you post-menopausal? If yes, what age? _____ □Yes □ No

Have you had a hysterectomy? If yes, what age? _____ □Yes □ No

Have you had your ovaries removed? If yes, what age? _____ □Yes □ No

Have you ever taken estrogen replacements? If yes, how long? _____ □Yes □ No

Have you ever had prolonged absence of periods other than child-birth or menopause? □Yes □ No

Do you exercise? If yes, what and how often? _____ □Yes □ No

Have you ever had an eating disorder? □Yes □ No