

Patient Name: _____

Date: _____

Date of Birth: _____ Ethnicity: _____ Referring Physician: _____

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you had a previous hip or vertebral fracture? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have any metal in your lower back or left hip? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you had any fractures during your adult life which did not result
From significant trauma? (auto accident?) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Did either of your parents ever have a hip fracture? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever taken Glucocorticoids? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have rheumatoid arthritis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have secondary osteoporosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you drink 3 or more alcoholic drinks per day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are you being treated for osteoporosis? | <input type="checkbox"/> | <input type="checkbox"/> |

11. Have you ever taken any of the following medications:

Actonel (i.e. risedronate)

Evista (i.e. raloxifene)

Fosamax (i.e. alendronate)

Miacalcin (i.e. calcitonin)

Reclast (i.e. zoledronate)

Vitamin D

Other (please specify): _____

Boniva (i.e. ibandronate)

Forteo (i.e. parathyroid hormone)

HRT (i.e. estrogen/hormone therapy)

Protelos (i.e. strontium ranelate)

Prolia (i.e. denosumab)

Calcium

12. Do you have any of the following medical conditions:

 Anorexia of Bulimia

 Asthma or Emphysema

 End stage renal disease

 Hyperparathyroidism

 Other (please specify): _____

 Any seizure disorder

 Cancer

 Inflammatory bowel diseases

 Hysterectomy

13. What was your maximum height? _____ in

14. Do you perform weight-bearing exercise regularly?

 YES NO

15. Do you regularly consume beverages?

 YES NO

16. Do you drink caffeinated beverages?

 YES NO

IF FEMALE

17. At what age did your period start? _____

18. How many full term pregnancies have you had? _____

19. Are you premenopausal?

 YES NO

20. Have you ever missed your period for more than 6 months

In a row (not including pregnancy or menopause)?

 YES NO