

Osteoporosis Risk Factor Survey



Date: _____

Patient Name: _____ MRN _____

Date of Birth: ___/___/___ Height: _____ Weight: _____

Referring Physician: _____

Ethnic Background: (circle one)

Asian Caucasian African-American Hispanic Other

List all prescribed medications: _____

Do you use tobacco products? Yes / No

Do you exercise at least 30 minutes daily, 3 times weekly? Yes / No

Is your diet low in calcium and dairy products? Yes / No

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

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

Have you had a hysterectomy? Yes / No
If yes, when? _____

Do you take hormone/estrogen replacement? Yes / No

Have you ever fractured a bone? Yes / No
If yes, which one(s) _____

Have you lost more than 2 inches in height since high school? Yes / No

Do you take thyroid medications? Yes / No
If yes, list medication, frequency and dose:

Do you take Prednisone or other steroids? Yes / No