

Rheumatology Associates- Osteoporosis Patient Questionnaire
(PLEASE PRINT ANSWERS)

Date: _____

Name: _____

First

MI

Last

Phone: Home _____ Work _____

Home Address: _____

Date of Birth: _____

Age: _____ Gender: _____

Height: _____ Weight: _____

Physician ordering this test: _____ Primary Physician: _____

Race: _____ African American _____ Caucasian _____ Asian _____ Hispanic

_____ other (please list) _____

Please answer YES or NO to the following questions

Have you ever had a bone density test before? _____ Where? _____

When? _____

Have you been diagnosed with Osteoporosis? _____

Have you had an X-Ray that has suggested you have osteoporosis? _____ If YES,
what type of X-Ray did you have? _____ When? _____ Where? _____

Does Osteoporosis run in your family? _____ Who? _____

Have you broken any bones after the age of 40? _____

If Yes, please select area of broken bones _____ Spine ___ Hip ___ Wrist _____ Ribs
_____ Other (please list)

Do you feel that you are shorter now than at the age of 40? _____ About how much
shorter do you feel you are? _____ (feet/inches)

Have you had back surgery? _____ If YES, when _____

Do you feel your spine is more rounded then when you were 40? _____

Do you have a history of falling? _____ Do you use a cane or walker? _____

(continued)

In the space below, please list ANY additional medications and/or vitamins you are currently taking along with their DOSES and HOW LONG you have been taking them

Do you have any of the following conditions/disorders? Please Answer YES or NO and LIST IN LAST COLUMN ANY ADDITIONAL INFORMATION

	<u>Yes</u>	<u>No</u>	<u>Additional Explanations</u>
Rheumatoid Arthritis			
Parathyroid Disease			
Thyroid Issues			
Hyperparathroidism			
Systemic Lupus Erythematosus			
Adrenal Gland Imbalance			
Paralysis			
Other Arthritic Conditions (Please List in last column) --->			
Stomach Surgery			
Bowel Surgery			
Ulcerative Colitis			
Crohn's Disease			
Cushings Disease			
Celiac Disease			
Lactose Intolerance			
Inflammatory Bowel Disease			
Back Deformity fractures, surgeries, scoliosis (Please List in last column) -->			
Have you ever suffered from or do suffer from anorexia nervosa			

FOR WOMEN ONLY:

Have you gone thru menopause? _____ If YES at what age? _____

Are you currently still going thru menopause? _____

Have you ever taken Hormones (estrogen/progesterone) _____ If YES what type _____ **What Dose** _____ How Long have you been on them _____

Do you have a history of breast lumps? _____ Do you have regular mammograms? _____ Did you have your ovaries removed? _____ If YES, what age? _____

Do you have a history of breast cancer? _____ How was it treated (radiation, chemotherapy, tamoxifen? _____

Did you have surgery for breast cancer? _____

Do you have a history of cancer of the womb(uterus)? _____

Do you have a history of blood clots? _____ If YES, were your treated with any blood thinners (example Coumadin)? _____ If YES, How long were you on blood thinners _____ **What dose** _____ Were these blood clots a single event? _____ If NO, how many times have you suffered from blood clots? _____

Patient Signature: _____

Date: _____