

Bone Density Questionnaire

Name _____ Date _____

Date of Birth _____ Height _____ Weight _____

Gynecologic History

Are (were) your periods regular between the ages of 18 and 40? YES NO

Did you ever have intervals with few or no bleeding cycles, other than during pregnancy?

YES NO

Age ___ Length of time _____

Have you had a hysterectomy? YES NO

If yes, what year _____ were your ovaries removed? _____

Have you entered menopause? YES NO

If yes, what year? _____

Medications

Are you taking hormone replacement pills or using patches? YES NO

Do you take cortisone, prednisone, or other steroids for treatment of asthma, arthritis, or cancer? YES NO

Do you take sleeping pills? YES NO

Do you regularly take a calcium supplement YES NO

Do you take medication for bone loss? YES NO

If yes what medication _____

Has there been a recent change in your bone loss medication? YES NO

Lifestyle

Do you take thyroid medication? YES NO

Do you smoke cigarettes? Pks/day _____ YES NO

Do you drink alcoholic beverages? Drinks/day _____ YES NO

Do you drink carbonated beverages? Cups/day _____ YES NO

Have you ever broken any bones? YES NO

What bone did you break? _____ What year? _____

Does anyone in your immediate family have osteoporosis? YES NO