



Office Use Only Date _____

RVP ID No _____

Ht: ____' ____" Weight ____ lbs

Height Diff = ____" Prev Study: _____

Spine _____ []2-4 TMH _____

Osteoporosis Questionnaire

Please complete and bring this form with you to your appointment.

Name: _____ Sex: []Female []Male Your Age: _____ years.

If you have had a previous bone density, when and where was that: _____

At your tallest, how tall were you? Ht: ____ feet ____ inches.

Who is your PCP? _____

Since age 40, have you broken any of the following? []Humerus(Arm) []Wrist []Spine []Hip []None
If YES, how did this happen?

Has a parent or sibling broken a hip from a simple fall or bump? []Yes []No

Do you have a mother, father, brother or sister with osteoporosis? []Yes []No

Do you smoke currently? []Yes []No

Do you drink more than 2 drinks of alcohol daily? []Yes []No

Have you taken more than 7.5 mg of prednisone daily for more than 3 months in the past? []Yes []No

Are you taking medications for: seizures, or transplant rejection? []Yes []No

Are you taking []Arimidex []Aromasin or []Femara (for treatment of breast cancer)? []No

Are you taking []Lupron []Zoladex or []Casodex for Prostate Cancer? []No

Please List the medications your take regularly here:

If you have taken medications for Osteoporosis, please list which ones, and approximately when your started and or stopped taking each one.