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**SUSSEX COUNTY MEDICAL ASSOCIATES**  
**123 NEWTON SPARTA ROAD**  
**NEWTON, NJ 07860**

**Osteoporosis QUESTIONNAIRE**  
**☎ 973-579-6300**  
**☎ 973-579-1524**

**Osteoporosis Questionnaire**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Name of referring doctor: \_\_\_\_\_

Race:  Native American  Caucasian  Hispanic  Black  Asian  Other

Current Weight: \_\_\_\_\_ Tallest Height: \_\_\_\_\_ Current Height: \_\_\_\_\_

Have you had hyperparathyroidism or a high calcium level in your blood?  Yes  No

Are you left or right handed?  R  L

Have you ever had surgery on your lower back or hip?  Yes  No

Have you had a previous bone density scan?  Yes  No

If yes, when: \_\_\_\_\_

Has a parent/sibling been diagnosed with osteoporosis?  Yes  No

Has a parent/sibling broken a bone after a fall?  Yes  No

Have you ever broken a bone? If yes, please provide details below.  Yes  No

What bone was broken? (Wrist, collar, spine, hip, etc.) \_\_\_\_\_

Was this from a simple fall?  Yes  No

If not from a simple fall, please describe the circumstances.  
 \_\_\_\_\_  
 \_\_\_\_\_

Your age when this occurred: \_\_\_\_\_

Are you currently a smoker?  Yes  No

Have you ever been a smoker?  Yes  No

Do you drink alcohol daily?  Yes  No

How much? \_\_\_\_\_

Do you walk/do weight bearing exercises for at least 20 minutes 3 times a week?  Yes  No

Have you been diagnosed with any of the following conditions?

Rheumatoid arthritis  Yes  No Osteoarthritis (wear & tear arthritis)  Yes  No

Celiac disease  Yes  No Crohn's disease  Yes  No

Ulcerative colitis  Yes  No Heartburn  Yes  No

Kidney stones  Yes  No Overactive thyroid or Thyroid cancer  Yes  No

Have you ever or are you currently taking the following medication?

Medication	Currently taking	Previously taken	
		When stopped	How long taken
Prednisone pills, or steroid pills or shots	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Inhaled corticosteroids (flovent, azmacort, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Thyroid medication	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Seizure medication	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Arimidex or Femera	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Lupron	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hormone replacement therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you take a **calcium supplement** (including Tums)? Yes No

Dose of tablets \_\_\_\_\_ How many times a day? \_\_\_\_\_

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Do you take **vitamin D**? Yes No

Dose of tablets \_\_\_\_\_ How many times a day? \_\_\_\_\_

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How many dairy servings do you have a day? \_\_\_\_\_

Have you been treated with any of the following medications?

Medication	Currently taking	Previously taken	
		When stopped	How long taken
Fosamax (alendronate)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Actonel (residronate)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Boniva (Ibandronate)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Reclast (Zoledronic acid)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Zometa	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Evista	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Miacalcin (calcitonin)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Forteo	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please provide the nurse with a full list of all your medications (including over-the-counter).

**Women only**

Before menopause, have you ever missed your period for 6 months or more, besides during pregnancy?

Yes  No

Have you gone through menopause?

Yes  No

If yes, at what age? \_\_\_\_\_

Have you had a hysterectomy?

Yes  No

If yes, at what age? \_\_\_\_\_

Have you had both of your ovaries removed?

Yes  No