Colorado Mountain Medical
Doctors you know and trust

Osteoporosis Questionnaire-

Date:_____Name:_____ DOB:_____ Female/Male

Weight:_____ Height:_____ Race:_____Referring Physician:_____

Your Medical History:

___Asthma
___Back Pain
___Back Surgery
___Celiac Disease
___Crohn's Disease or
Ulcerative Colitis
___Diabetes
___Cancer:_____
___Other:_____

___Hip Surgery
___Hyperparathyroidism
___Hyperthyroidism
___Hypothyroidism
___Kidney/Liver Disease
___Osteoarthritis
___Osteoporosis/Osteopenia

___Rheumatoid Arthritis
___Seizure Disrder
___Testosterone deficiency
___Vitamin D deficiency

Family History of Osteoporosis
Yes / No

Has either of your parents ever fractured their hip? Yes / No

Have you fractured your back/hip/wrist as an adult?_____

Gynecologic (Women Only)

Have you gone through Menopause?:_____ At what age?_____ Hysterectomy?_____

Have you had your ovaries removed?_____ At what age?_____ One or Both?_____

Are you currently on hormone replacement?_____ How many years?_____

Medications that you take:-

___ Bisphosphonates: (Actonel / Boniva / Fosamax)

___Calcium
___Estrogen/Progesterone
___Estiva
___Diuretics
___Thyroid Replacement: Synthroid / Armour

___Forteo
___Heparin
___Phenytoin/phenobarbital
___Prednisone

___Prolia / Xgeva
___Tamoxifen
___Testosterone

___Vitamin D
___Seizure Medication
___Nasal Calcitonin

Life style:

Alcohol use? Yes / No How many per week?_____ Caffeine use? Yes /No How many per day?_____

Tobacco Use Yes /No How many per day?_____ How many years?_____

Exercise: _____ Frequency?_____