

# Women's Healthcare Associates-Osteoporosis Questionnaire

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DO NOT TAKE A CALCIUM SUPPLEMENT THE DAY OF TEST

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

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|-----|---|-------|----|
| 1.  | Did you experience menopause before age 45?   | Yes   | No |
| 2.  | Has anyone in your family been diagnosed with osteoporosis?                                   | Yes   | No |
| 3.  | Has anyone in your family had a hip fracture?   | Yes   | No |
| 4.  | Have you ever had breast cancer?  | Yes   | No |
|     | If you answered yes, were you treated with Tamoxifen?   | Yes   | No |
| 5.  | Are you of either Caucasian or Asian descent?   | Yes   | No |
| 6.  | Are you fairly thin or of small build?  | Yes   | No |
| 7.  | Do you take, or have you ever taken, steroids, (commonly used to treat asthma and arthritis)? | Yes   | No |
|     | Thyroid hormones (Synthroid, L-Thyroxine)?  | Yes   | No |
|     | Estrogen replacement hormones?  | Yes   | No |
| 8.  | Do you smoke or have you smoked in the past?  | Yes   | No |
| 9.  | Do you generally have more than one alcoholic drink a day?                                    | Yes   | No |
| 10. | Do you exercise fewer than 3 times a week?  | Yes   | No |
| 11. | Do you avoid dairy products?  | Yes   | No |
| 12. | Do you take calcium supplements?  | Yes   | No |
| 13. | What height were you in high school?  | _____ |    |
| 14. | Have you broken any bones as an adult   | Yes   | No |
| 15. | Have you had any bone surgery?  | Yes   | No |
| 16. | Do you have any diseases or problems of the bones?  | Yes   | No |
| 17. | Have you notice any rounding of you shoulders or experienced any unexplained back pain?       | Yes   | No |
| 18. | Have you had any barium or radioactive substances in the past week?                           | Yes   | No |
| 19. | Do you have diabetes?   | Yes   | No |

Referring Physician \_\_\_\_\_

Address \_\_\_\_\_