EMKEY ARTHRITIS AND OSTEOPOROSIS CLINIC

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OSTEOPOROSIS RISK FACTOR QUESTIONNAIRE

Name:	Today's Date: _____/_____/____	Date of Birth: _____/_____/_____
Please forward a copy of my DEXA/VFA to the following physicians:		

The following section is for <u>female</u> patients only:

Have you been through menopause?	Yes	No
If so, at what age?_____		
Have you had a hysterectomy?	Yes	No
Are you currently or have you taken hormones in the past?	Yes	No

Please indicate if you have ever had any of the following medical problems:

□ Thyroid/Parathyroid Problems	□ Asthma	□ Diabetes
□ Rheumatoid Arthritis	□ Gastrointestinal Problems	□ Back Pain
□ Kidney Problems / Kidney Stones	□ Cancer	

Please circle or mark "Yes" or "No" to the following questions:

Do you have a family history of osteoporosis?	Yes	No
Have you ever smoked?	Yes	No
If so, how many years? _____		
Do you drink alcoholic beverages?	Yes	No
Have you lost height?	Yes	No
Have you ever used steroids (such as PREDNISONE) to treat chronic illness?	Yes	No
Have you ever fractured a bone?	Yes	No
Would you want to be notified of clinical trials for osteoporosis?	Yes	No

Do you currently or have you previously taken any of the following medications for bone health?

	Date Started (mm/yyyy)	Date Stopped (mm/yyyy)		Date Started (mm/yyyy)	Date Stopped (mm/yyyy)
□ Actonel			□ Zometa		
□ Atelvia			□ Prolia		
□ Evista			□ Reclast		
□ Forteo			□ IV Boniva		
□ Fosamax			□ Boniva		
□ Calcium			□ Vitamin D		

If you have stopped taking one of these medications, please write the reason for stopping below:

_____

_____

_____