Height:_____ Weight:_____

Race:_____Previous Height:_____

Are you pregnant?__Y __N

1. Have you fractured any bones in the last 10yrs? If yes, which bone?_____ Y N
2. Is there a family history of osteoporosis? Y N
3. Do you have osteoporosis? Y N
4. Do you smoke? If yes, how many packs per day?_____ How many years_____ Y N
5. How many servings of dairy products do you consume per day_____
6. Do you take calcium supplement with Vitamin D Daily? Y N
7. Do you exercise at least 3 times per week? Y N
8. Do you drink more than two alcoholic drinks per day? Y N
9. Do you take any of the following medications and when?
    a. Steroids (Prednisone, Cortisone, etc.) Y N
    b. Thyroid medications Y N
    c. Anticonvulsant (for seizures, epilepsy) Y N
    d. Please list any Osteoporosis medications you are currently taking:_____
10. Do you have any of the following conditions?
    a. Partial or complete paralysis Y N
    b. Hyperthyroidism (overactive thyroid) Y N
    c. Kidney Disease Y N
    d. Rheumatoid Arthritis Y N
    e. Other Arthritis Y N
    f. Intestinal or Bowel Disease Y N
    g. Eating Disorders Y N
    h. Diabetes Y N

REMAINING QUESTIONS ARE FOR WOMEN ONLY

1. Have you gone thru menopause (change of life)? If yes, at what age?_____ Y N
2. Do you have amenorrhea (Never started periods or ended at young age)? Y N
3. Are you taking hormones (Premarin, Estrogen)? Y N
4. Have you had any of the following conditions:
    a. Hysterectomy Y N
    b. Ovaries removed Y N
    c. Blood Clots Y N
    d. Breast Cancer Y N
    e. Family history of Breast Cancer Y N