

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Physician Name

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Height

\_\_\_\_\_  
Weight

\_\_\_\_\_  
Age of Menopause

\_\_\_\_\_  
Number of Child Births

1. Do you have a small, thin frame?  Yes  No
2. Are you a Caucasian or Asian?  Yes  No
3. Are you a post-menopausal woman?  Yes  No
4. Have you had an early or surgically induced menopause?  Yes  No
5. Did you take birth control pills in the past?  Yes  No
6. Have you been taking high doses of thyroid medication or high or prolonged doses of cortisone-like drugs for asthma, arthritis or other diseases?  Yes  No
7. Is your diet low in dairy products or other sources of calcium?  Yes  No
8. Do you exercise regularly?  Yes  No
9. Do you smoke cigarettes or drink alcohol in excess?  Yes  No
10. Do you have a family history of osteoporosis?  Yes  No
11. Have you lost over an inch in height?  Yes  No
12. Do you drink two or more soft drinks, tea or coffee daily?  Yes  No
13. Have you ever had a fracture?  Yes  No  
If yes, what part of your body? \_\_\_\_\_