WGM Ob/Gyn Bone Density Questionnaire Today's Date_____

Patient Name_____ Date of birth_____

1. Have you ever had a bone density test before? ☐Yes ☐No If YES – Where and when?_____

2. Are you currently or have you previously taken medication for osteoporosis/osteopenia? ☐Yes ☐No
If yes, what medication?_____ How long have you been taking them?_____

3. Do you take calcium supplements? ☐Yes ☐No If yes, how much do you take?_____

4. Do you take hormone replacement? ☐Yes ☐No If yes, what do you take?_____

5. Have you ever fractured any bones in your adult life? ☐Yes ☐No If yes, what bone(s)? _____

How did it occur? _____ Did you ever have a hip replacement? ☐Yes ☐No

6. Do you take oral steroids (Glucocorticoids) or have you taken oral steroids longer than 3 months? ☐Yes ☐No
If yes, how long have you taken them? _____

7. Have either of your parents or siblings fractured a hip? ☐Yes ☐No

8. Do you currently smoke? ☐Yes ☐No

9. Do you have a confirmed diagnosis of Rheumatoid arthritis? ☐Yes ☐No

10. Did you experience menopause prior to 45 years old? ☐Yes ☐No Menopause Age_____

11. Do you drink more than 3 alcoholic beverages per day? ☐Yes ☐No

12. Do you have any endocrine disorders (Thyroid, Diabetes etc)? ☐Yes ☐No
If yes, what disorder(s) _____

13. Do you have any gastrointestinal disorders (IBS, Malabsorption, Celiac) or have you had bulimia/anorexia?

☐Yes ☐No If yes, what disorder(s) _____

14. Do you have liver disease? ☐Yes ☐No

15. Do you take any of the following medications? (Circle any that apply)

Anticonvulsants / Antirejection drugs / Thyroid medications / Heparin / Lithium / Arimidex

16. Do you have (or had) any of the following diseases? (Circle any that apply) Cushings disease / Multiple Sclerosis /

COPD / Myeloma / Thalassemia / Leukemia / Breast Cancer / Metastatic disease (cancer)