

**CARE FOR WOMEN
OSTEOPOROSIS DIAGNOSTIC CENTER
Risk Factor Survey**

Date: _____

Name: _____ Phone: _____

Address: _____

Physician: _____

Purpose of Bone Density Test: _____

Sex: _____ M _____ F Race: White _____ Black _____ Age: _____ DOB: _____

Hispanic _____ Asian _____ Ht: _____ Wt: _____

Family Hx. Osteoporosis (hip fx, vert fx, bt. Loss) Yes _____ (if yes, who?) _____ No _____

Any Fracture History? _____

Loss of Height: Yes _____ No _____

of Pregnancies: _____

Medication/Risk Factors:

CURRENT

Hormone Therapy: _____

Steroid Therapy: _____

Thyroid/Parathyroid: _____ Radiation/Chemo _____

Calcium: _____

Vitamins/Minerals: _____

Bone meds. Rx, _____ If yes, what & how long: _____

Other Current meds _____

Kidney Problems/Stones

Back Pain Occasionally Most of the time

Other Health Problems _____

Lifestyle:

Regular Exercise: (If yes, what) _____

Smoking: (If yes, how much poer day) _____

Caffeine(per day) _____ Coffee _____ Tea _____ Cola _____ Alcoholic Drinks _____

Foods: (if yes, specify amount per day or amount per week)

Milk, buttermilk, OJ w / Calcium Yes/No _____

Calcium (300mg/Vit D 100/IU per cup) Yes/No _____

Ice Cream/Frz. Yogurt (200mg/c) Yes/No _____

Cheese (200mg/oz) Yes/No _____

Cottage Cheese (50mg/ 1/3c) Yes/No _____

Yogart (200mg/6oz) Yes/No _____

Dark Green Veg. (200mg/6oz) Yes/No _____