Date: _____

CARE FOR WOMEN
OB/GYN

OSTEOPOROSIS DIAGNOSTIC CENTER
RISK FACTOR SURVEY

Patient Name: _____ Phone: ( ) _____

Mailing Address: _____

Physician Name: _____

Purpose of Bone Density Test: _____

Sex: _____ M _____ F Age: _____ DOB: _____

Race: _____ White _____ Black _____ Hispanic _____ Asian Height: _____ Weight: _____

Family Hx. Osteoporosis (hip fx, vert fx, bt. loss): ___Yes ___ No

(If yes, who?): _____

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: _____ _____
Other Current Meds: _____ _____
_____ _____
Kidney Problems/Stones
Back Pain:

Other Health Prob.: _____

LIFESTYLE: ☐ Occasionally ☐ Most of the Time

Regular exercise: (If *Yes*, what?) _____
Smoking: (If *Yes*, how much per day?) _____
Caffeine (per day): _____ Coffee _____ Tea _____Cola _____ Alcoholic Drinks

FOODS (If *Yes*, specify amount per day or per week):

Milk, Buttermilk, OJ with Calcium Yes/No: _____
(ca: 300 mg; Vt D 100 IU per cup) Yes/No: _____
Ice Cream/Frz. Yogurt (200 mg/c) Yes/No: _____
Cheese (200 mg/6 oz) Yes/No: _____
Cottage Cheese (50 mg/1/3c) Yes/No: _____
Yogurt (200 mg/6 oz) Yes/No: _____
Dark Green Veg. (200 mg/6 oz) Yes/No: _____