CARE FOR WOMEN OSTEO CENTER
Osteoporosis Risk Factor Survey

Date: _____ Cell #: (___)_____
Name: _____ Home #: (___)_____
Physician Who Ordered This Test: _____
Reason this test was ordered: □ Routine screening □Other: _____
Sex: ___M ___F Race: ___White ___Black Age: _____ DOB: _____
___ Hispanic ___Asian Ht: _____ Wt: _____
Family Hx Osteoporosis □Yes □No If Yes, Who:_____
Do You Have a History of Bone Fractures: □Yes □No If Yes, Year of Fracture:_____
Have you swallowed any barium for testing in the last 10 days? □Yes □No
Do you have a sensitive stomach or constipation problems? □Yes □No

MEDICATION/RISK FACTORS

CURRENT MEDICATIONS (Answer Yes or No; If yes, check appropriate boxes
Hormone Therapy--
(Prescription Only): □Yes □No Name: _____□ Oral □ Vag □ Inj
Steroid Therapy: □Yes □No
Thyroid/Parathyroid: □Yes □No Name: _____□ AM □ PM
Chemo or radiation treatment? □Yes □No If yes, when/why _____
Calcium
(Supplements Only): □Yes □No Name: _____ # of mgs per pill: _____
Vit D3,SEPARATE PILL □Yes □No # of IUs: _____
Multi Vitamins only: □Yes □No
Rx for Bone Loss: □Yes □No Name: _____
How long have you been taking RX for bones? _____
Other Current Meds:_____
_____
Kidney Problems/
Stones □Yes □No # or episodes of stones_____ Year they occurred_____
Back Pain: □Yes □No If Yes: □Occasionally □Most of the Time

LIFESTYLE:
Regular exercise (What and How Often): _____
Smoking: □ Yes □No If Yes, How many per day: _____
Caffeine □ Coffee # Per Day_____ or # Per Week _____
□ Tea # Per Day_____ or # Per Week _____
□ Cola # Per Day_____ or # Per Week _____
□ Alchoholic Drinks # Per Day_____ or # Per Week

FOODS—Circle "Yes" or "No" and list the approximate amt of calcium per day or per week:

Milk (any kind), Buttermilk	**Yes/No: Amt per day_____**	**Amt per week _____**
OJ w/Calcium (300 mg/cup)	**Yes/No: Amt per day_____**	**Amt per week _____**
Ice Cream (200mg/c)	**Yes/No: Amt per day_____**	**Amt per week _____**
Cottage Cheese (50 mg/1/3 c)	**Yes/No: Amt per day_____**	**Amt per week _____**
Cheese (200 mg/oz or slice)	**Yes/No: Amt per day_____**	**Amt per week _____**
Regular Yogurt (300 mg/6 oz)	**Yes/No: Amt per day_____**	**Amt per week _____**
Greek Yogurt (400 mg/6 oz)	**Yes/No: Amt per day_____**	**Amt per week _____**
Dark Green Vegetables	**Yes/No: Amt per day_____**	**Amt per week _____**

(<u>Mainly</u> Cooked Spinach, Broccoli, Kale, Mustard, Turnip Greens)
<u>Do Not List</u> Salads, Green Beans or Peas