MidAmerica Hand to Shoulder Clinic
MidAmerica Orthopaedics
OrthoNow Orthopaedic Immediate Care

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Osteoporosis Screening Information Questionnaire

Patient Name: _____ Date of Birth: ____/____/____

Sex: ☐ Male ☐ Female Age: _____ Height: _____ Weight: _____

Ethnicity: ☐ Caucassian ☐ Black ☐ Hispanic ☐ Asian ☐ Other: _____

Please indicate your responses to the following questions.	**Yes**	**No**	**Unknown**
Are you a male over the age of 70?			
Are you a female over the age of 65?			
Did you enter menopause earlier or less than 45 years of age?			
Do you have a history of steroid therapy?			
Do you have a history of smoking cigarettes? Packs per day: _____			
Have you ever broken any bones? If yes, what year? _____ Site: _____ How? _____			
Does anyone in your immediate family have a history of hip fractures? ☐ Father ☐ Mother ☐ Sister ☐ Brother			
Do you have a history of low body weight? ☐ Yes ☐ No What was your lowest? Height _____ Weight _____			
Do you have a history of Thyroid Disease?			
Do you have a history of Renal Disease?			
Do you take any steroids orally? (Greater than 3 months)			
Do you lead a sedentary lifestyle?			
Have you had a bone density screening within the last 2 years? If yes, when? _____			

I certify that the information provided above is to the best of my knowledge.

Patient Signature: _____ Date: ____/____/____