

**ACCESS SPORTS MEDICINE & ORTHOPAEDICS
OSTEOPOROSIS SCREENING PROGRAM
RISK FACTOR ASSESSMENT**

Name _____ Date of Birth _____

Current Height _____ Tallest Height _____ Weight _____

Have you ever had a DEXA scan prior to now? YES NO

 If so, when and where? _____

 What were the results? _____

Do you have a family history of osteoporosis? YES NO

Since the age of 40, have you broken a bone? YES NO

 If YES:

Age	Bone broken	How did injury occur?

Please list **all** medications you are currently taking: _____

Have you ever taken any of the following types of medications?

- Prednisone (or other steroid medication) *for longer than 3 months?*

YES NO

- Medications for seizures/epilepsy?

YES NO

- Cancer chemotherapy?

YES NO

- Hormone replacement therapy (estrogen)?

YES NO

- Other hormonal medications (such as testosterone, tamoxifen, Evista)?

YES NO

- Osteoporosis medications (such as Actonel, Fosamax, Boniva, Miacalcin, Forteo)?

YES NO

- Please give details on any “YES” answers above: _____

How many serving of each of the following do you eat/drink each day?

Milk _____ Yogurt _____ Cheese _____

Calcium-fortified juices _____

Caffeine (coffee/tea/soda) _____ Alcohol _____

Do you take a multivitamin? YES NO

Do you take any calcium or Vitamin D supplements? YES NO

How much calcium do you take? _____

Do you smoke? YES NO

Do you exercise on a regular basis? YES NO

If yes, what do you do for exercise? _____

How many times have you fallen in the last year? _____

If you are female, have you gone through menopause? YES NO

If yes, at what age? _____

Have you had a hysterectomy? YES NO

If yes, at what age? _____ Were your ovaries removed? YES NO

Who is your primary care physician? _____