



Name: _____ Date: ____/____/____

Date of Birth: _____ Age: _____

Race: Caucasian Hispanic Black Asian Native American Other _____

Current weight: _____ Current height: _____ Height at age 20: _____

How would you rate your overall health? Excellent Good Fair Poor

Do you currently smoke? Yes No

Do you drink alcohol? Yes No

Do you drink coffee or soda? if so, _____ ounces per day Yes No

Do you exercise regularly? Yes No

Have any of your first-degree relatives had a fracture? Yes No

Did your mother ever break her hip? Yes No

Have you had a fracture as an adult? Yes No

If yes, which bones have you broken? _____

Do you have diabetes? Yes No

Do you have rheumatoid arthritis? Yes No

Do you have epilepsy? Yes No

Have you fallen in the last 12 months? Yes No

Have you ever had hyperthyroidism? Yes No

Have you ever had hyperparathyroidism? Yes No

Have you ever had sprue or celiac disease? Yes No

Do you have Crohn's Disease? Yes No

Do you have ulcerative colitis? Yes No

Do you have kidney or liver disease? Yes No

Have you ever had cancer? Yes No

Do you have problems with your balance? Yes No

Can you get up from a chair without using your arms? Yes No

Do you have uncorrected problems with your vision? Yes No

Have you ever had any part of your stomach removed surgically? Yes No

Have you ever had a gastric/intestinal bypass operation? Yes No

Do you take or have you ever taken any of the following:

Hormone replacement or estrogen replacement therapy? Yes No

Corticosteroids, such as prednisone or cortisone? Yes No

Lithium? Yes No

Thyroid hormone? Yes No

Insulin? Yes No

Dilantin®? Yes No

Calcium supplements? Yes No

Multivitamins? Yes No

Lupron® (leuprolide) or Zoladex® (goserelin)? Yes No

Have you ever had a bone density test before? Yes No

If yes, when and where? _____

Are you postmenopausal? Yes No

If yes, at what age did you become menopausal? _____

Have you had children? Yes No