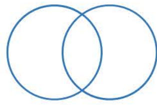

CAPITOL ENDOCRINOLOGY INC.
Personalized Diabetes Care

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OSTEOPOROSIS QUESTIONNAIRE

1) When & where did you last have a **Bone Density or DXA**? ____
2) Have you **lost height**? ❑Yes ❑No If yes, please explain how much height you've lost? ____________________
3) Did you ever have a **fracture in adult life**? ❑Yes ❑No If yes, please explain ___________________________
4) Did you ever have **back injury or surgery**? ❑Yes ❑No If yes, please explain ___________________________
5) Have you or your mother had a **hip fracture** or replacement? ❑Yes ❑No
If yes, please explain ____
6) Do you have any relatives that have osteoporosis? ❑Yes ❑No If yes, please explain ________________________
7) Do you have a tendency for **falls**? ❑Yes ❑No If yes, please explain ___________________________________
8) Are you a current **smoker**? ❑Yes ❑No Have you been a smoker? ❑Yes ❑No
Please explain how much, how often, and when you quit. _______________________________________
9) Do you drink **alcohol**? ❑Yes ❑No If yes, then how frequently? _____________________________________
10) Do you drink excessive **soda**? ❑Yes ❑No If yes, then how frequently?________________________________
11) Do you eat or drink **dairy products**? ❑Yes ❑No How much & how frequently? _______________________
12) Do you take **Calcium**? ❑Yes ❑No If yes, please specify type, dose and frequency. _______________________
13) Do you take **Vitamin D**? ❑Yes ❑No If yes, please specify type, dose and frequency. _______________________
14) Questions for **Men**
- Any problems with sexual function? ❑Yes ❑No
- Have you ever had prostate problems? ❑Yes ❑No If yes, how was it treated? _______________________
- Do you have low testosterone? ❑Yes ❑No If yes, are you on testosterone? ❑Yes ❑No
  - If yes, what kind & how long have you been taking it? ___________________________________

15) Questions for **Women**
- Did you have irregular menses? ❑Yes ❑No
- History of hysterectomy? ❑Yes ❑No
- Have your ovaries been removed? ❑Yes ❑No
- When did you go through menopause? ____
- Have you ever taken estrogen? ❑Yes ❑No If yes, for how long & why was it discontinued? ______________

16) Do you have any **dental** problems? ❑Yes ❑No
- Have you had a dental or oral infection that had difficulty healing?
- History of Osteonecrosis of the jaw? ❑Yes ❑No If yes, please explain ______________________________
- How often do you see a dentist? _____________ When was the last time you saw a dentist? _____________

17) Please check if you have ever taken the following medications.

❑Evista (Raloxifene)
❑Fosamax (Alendronate)
❑Actonel (Risedronate)
❑Boniva (Ibandronate) Pills or IV
❑Pamidronate
❑Reclast (Zoledronic acid)
❑Tymlos (Abaloparatide Injection)
❑Forteo (Teriparatide Injection)

18) Please check if you have any of the following conditions.

❑Diabetes
❑Vitamin D Deficiency
❑Gastric bypass or GI surgery
❑Malabsorption
❑Multiple Myeloma
❑Lupus
❑Parkinson's disease
❑Rheumatoid Arthritis
❑Celiac disease
❑Crohn's disease or Colitis
❑Anorexia
❑Blood disorders
❑Multiple Sclerosis
❑COPD
❑Alcoholism
❑Hypercalciuria
❑Muscle weakness
❑Problems walking or Imbalance
❑Vision problems
❑Kidney disease

19) Please check if you are taking or have taken any of the following in the past.

❑Cancer therapy drugs
❑Radiation therapy
❑Cyclosporine or Tacrolimus
❑Thyroid hormones
❑Anticoagulants (heparin)
❑SSRI, SSNI (depression medications)
❑Thiazolidinediones (TZD) (Diabetes medicine)
❑Gonadotropin releasing agonist
❑Aromatase inhibitors (Tamoxifen)
❑Proton Pump Inhibitors (stomach medicine)
❑Oral Steroid
❑Lithium
❑Seizure control medicine
❑Parenteral Nutrition
❑Methotrexate