



4151 HOLIDAY STREET, N.W. – CANTON, OHIO 44718 – TELEPHONE (330) 492-8001  
 FAX (330) 492-2080 – WWW.ATRIUMOBGYN.COM

## Osteoporosis Database Questionnaire

Your name:		
Date of birth:	Age:	
Address:		
City:	State:	Zip:
Your Home Phone	Your Work Phone	
Your Doctor's Name:		
At your tallest, what was your height in feet and inches?		
If you are still menstruating, what was the date of your last period?		
If passed menopause, estimate the year you last had a menstrual period?		
How many children have you given birth to?		

Below, please list all medications (prescription and over-the-counter), vitamins and mineral supplements, natural herbs or drugs, and homeopathic therapies you are currently taking.

Medication Name	Dose	Number taken daily

### Patient's Medical History

From the list below, please circle the number by any condition that applies to you now or in the past.

Personal History			
10	I am female	290	I am Hispanic
275	I am male	105	I am Northern European Ancestry
90	I am Caucasian	65	I have a family history of osteoporosis
285	I am African-American	85	I have used tobacco regularly now or in the past
95	I am Asian	120	I have lost over an inch in height

*Please turn page to the other side*



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<b>Medical History</b>			
245	I have a history of kidney stone	325	I have had a vertebral compression fracture
70	I have a history of an over-active thyroid gland	320	I have had a wrist fracture
395	I have a history of phlebitis	330	I have had a hip fracture
400	I have a history of pulmonary embolism	335	I have had a rib fracture
430	I have a history of an under-active thyroid gland	340	I have had a pelvic fracture
240	I have a history of high blood calcium level	345	I have had a stress fracture
75	I have a history of hyperparathyroidism	350	I have had a fracture not listed above
420	I have a history of osteoporosis	435	I have a dowager's hump of the spine
325	I have had a spine fracture	425	I have back pain
45	I have a history of alcoholism	155	I have a history of anorexia nervosa or bulimia
50	I have rheumatoid arthritis	140	I have a history of multiple myeloma
<b>Female Reproductive System History</b>			
15	I had a premature menopause	380	I have uterine fibroids
20	I have passed menopause	415	I had a hysterectomy (surgical removal of the uterus)
25	I lost my period for a while before it returned	390	I have a history of cervical or uterine cancer
40	My periods began after age 16	361	I have fibrocystic breast disease
160	I lost periods due to a heavy exercise routine	405	I have a history of breast cancer
165	I had both ovaries removed surgically	363	I have a family history of breast cancer
35	I have a history of irregular menstrual periods	25	I have a history of amenorrhea
<b>Medication History</b>			
60	I have used cortisone-like drugs	170	I have used thyroid hormone pills
200	I have used phenobarbital or phenytoin (Dilantin)	180	I have a history of treatment for cancer with chemotherapy
220	I use Mylanta or Maalox often		
<b>Diet and Exercise History</b>			
225	I usually eat meat twice a day	305	I exercise 3 or more times weekly
235	I follow a vegetarian diet	110	I don't exercise regularly
80	I use 2 or more alcoholic drinks daily	210	I use 2 or more soft drinks daily
310	I regularly include dairy in my diet	215	I use 2 or more cups of coffee or tea daily
195	I avoid milk and other dairy foods		

Are you seeing a healthcare provider for bone loss? Yes / No

Is this health care provider requesting a copy of this Bone Density? Yes / No

If yes – healthcare provider's name: \_\_\_\_\_