OSTEOPOROSIS SCREENING QUESTIONNAIRE

Forename: .... Date of Birth: ....

Surname: .... Weight: ....

Height: ....

Please circle as appropriate

1. Do you have a family history of osteoporosis or hip fracture YES / NO

2. Have you fractured any bones in the last ten years. YES / NO

3. Have you lost any height?
If yes, how many ....inches ....cms

4. Have you ever had:
   - Anorexia/bulimia? YES / NO
   - Liver disease? YES / NO
   - Breast cancer? YES /NO
   - Rheumatoid arthritis? YES / NO
   - Thyroid disease? YES / NO

5. Have you ever taken steroids?

6. Do you smoke / or have smoked?

7. Do you avoid milk / dairy products in your diet or have specific dietary restrictions YES / NO

   If yes, please give details. ....

8. Do you drink alcohol regularly? YES / NO

   If yes, how many units per week? ....
   (½ pint of beer/1 glass of wine/1 spirit measure = 1 unit)

9. Do you take regular exercise such as a daily walk? YES / NO

10. Have you ever been prescribed:
    - Alendronate (Fosamx) YES / NO
    - Risedronate (Actonel) YES / NO
    - Etidrinate (Didronel PMO) YES / NO
    - Raloxifene (Evista) YES / NO
    - Calcium and/or Vitamin D YES / NO

Continued overleaf/..................

For women only

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11. Is there any possibility that you may be pregnant? YES / NO

12. At what age did you start your periods? ....

13. Have you ever experienced loss of periods for more than three months in a row? YES / NO

14. Have your periods finished? YES ? NO
If yes, at what age? ....

15. Have you had surgery which involved removal of both ovaries? YES / NO

16. Are you taking hormone replacement therapy (HRT)? YES / NO

17. Have you taken hormone replacement therapy (HRT) in the past? YES / NO
If yes, when? ....

Signature: .... Date: ....

For Centre use

Signature of Radiographer: .... Date:..

REFERRING GP - NAME / ADDRESS

GP Name: ....

Address: ....

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