OSTEOPOROSIS RISK QUESTIONNAIRE

PARADISE
ARTHRITIS & RHEUMATOLOGY

Name _____ Today's Date ____/_____/_____

Date of Birth_____/_____/_____ Age _____ Your Rheumatologist Dr_____

Height_____ Weight_____

Medical History

Please Tick the Appropriate Box	Yes	No	Unknown
Have you taken any of the following medications or treatments			
Steroid (prednisone, cortisone etc)			
Thyroid medication			
Seizure medication			
Chemotherapy			
Have you ever broken a bone? Hip Spine Wrist Other_____			
Do you have or have had previously any of the following conditions Over active thyroid Under active thyroid Parathyroid disease Liver disease Kidney disease Type 1 diabetes Rheumatoid arthritis Paget's Disease Gastrointestinal disease or malabsorption			
Do you have a family history of osteoporosis or bone disease?			
Do you think you have lost height as you have grown older?			
Do you have teeth that need to be fixed by a dentist soon?			

Lifestyle and Nutrition

Do you smoke? How many per day			
Did you smoke in the past?			
Are you vegetarian or eat mainly vegetables			
Do you drink more than 2 alcoholic drinks per day			
Do you have 2 alcohol free days per week			
Do you consume more than 3 cups of coffee per day?			
Do you consume cola drinks regularly?			
Do you have a regular exercise routine? How many times per week _____			
Do you have a condition that that makes exercise difficult?			

Family History

Did your mother or father have osteoporosis or break a bone?			
Did your mother or father develop a forward stoop or lose height?			

Vitamin D

Please tick the appropriate box	Yes	No
Do you receive sun exposure on a daily basis?		
Do you wear sunscreen when out in the sun?		
Do you take vitamin D supplements?		
If yes please record name of tablet and dose in units per day		

Calcium

Do you take any calcium tablets?		
If yes please record the name of the tablets and the amount of tablets taken daily		
How many glasses of milk do you drink each week		
How many serves of Yoghurt do you have each week		
How many slices of cheese do you have each week		

Risk of Falling

Please tick the appropriate response	Yes	No
Have you fallen in the last 12 months?		
Do you live alone?		
Do you use a walking stick, frame or support?		
Do you suffer with frequency or continence problems?		
Do you suffer with sleep problems or insomnia?		
Do you use any type of sedation or strong painkillers?		
Do you experience low blood pressure?		
Do you have any sight impairment?		
If yes please specify		
Do you have steps or stairs at your house?		
Do you have loose mats or rugs on the floor?		
Do you have handrails in the toilet or bathroom?		
Do you have a sensor light outside?		

What do you think is your risk of falling? Please circle LOW MEDIUM HIGH

Questions for Women only

Please Tick the Appropriate Box	Yes	No	Unknown
Have you gone through menopause			
Did this occur before age 45 years			
Did you have a hysterectomy Were your ovaries also removed			
Have you or do you take hormone replacement?			