Osteoporosis Questionnaire

If you’re coming to our center for this test, print this page, fill out the form and bring it in with you on the day of your appointment.

FIRST NAME  
LAST NAME  
AGE  DATE OF BIRTH

SEX ☐ MALE ☐ FEMALE
SOCIAL SECURITY NUMBER: - - -

ADDRESS  
CITY  
STATE  
ZIP

HOME PHONE - - -

WEIGHT  HEIGHT  TALLEST HEIGHT

ARE YOU LEFT -OR- RIGHT HANDED? ☐ LEFT ☐ RIGHT

* WHAT AGE DID YOU HAVE YOUR FIRST PERIOD?

* WHAT AGE DID YOU HAVE YOUR LAST PERIOD?

ARE YOU TAKING HORMONES? ☐ YES ☐ NO

IF YES, WHAT TYPE?

* DID YOU EVER HAVE A HYSTERECTOMY? ☐ YES ☐ NO

* ARE YOU ALLERGIC TO ANY MEDICATION? ☐ YES ☐ NO
IF YES, WHAT TYPE?

* DID YOU EVER BREAK ANY BONES IN THE PAST?  ☐ YES  ☐ NO

IF YES, WHICH ONES?

NAME OF PHYSICIAN ORDERING PROCEDURE?

* IF APPLICABLE