COUNTIES MANUKAU HEALTH

Osteoporosis Questionnaire

Name: _____ Date of Birth: _____ Patient number/NHI: _____

Please fill in and bring with you to the appointment. This information together with the results of your bone density scan will help us to estimate your risk of having an osteoporotic fracture in the next few years. This will assist in providing advice to you and your doctor about whether you need any bone treatment.

1. Have you had any **broken bones** (fractures) during your adult life? ☐ Yes ☐ No
   If yes:

Which bones were broken?	How old were you?	How did it happen?
a. _____	_____	_____
b. _____	_____	_____

2. Did either of your **parents** break their hip? ☐ Yes ☐ No
3. Did either of them break other bones ☐ Yes ☐ No
   If yes, which bones?_____
4. Are you a current **smoker**? ☐ Yes ☐ No
   If yes, how many cigarettes per day? _____
5. Are you taking **steroid** tablets e.g. Prednisone? ☐ Yes ☐ No
   If yes, what dose? _____
6. Do you have:

a. Rheumatoid arthritis?	Yes / No	e. Body weight < 55kg (8 2/3 stone) long term	Yes / No
b. Celiac disease?	Yes / No		
c. Type I diabetes mellitus?	Yes / No	f. High blood calcium	Yes / No
d. Chronic liver disease?	Yes / No		

7. If female, did you stop having periods before you turned 40? ☐ Yes ☐ No
8. Do you drink **more than 3** beers/glasses of wine/nips of spirits most days? ☐ Yes ☐ No
9. Have you had any **falls** in the past 12 months? ☐ Yes ☐ No
   If yes, how many? _____
10. Have you had any major medical illnesses? Yes / No If so, please list them:
    _____
    _____
    _____
    _____
11. Have you ever been treated for cancer? ☐ Yes ☐ No
    If so, what type of cancer?_____

Hand this form to the Bone Density staff before your appointment