## Osteoporosis Screening Questionnaire

**Name:** ____________________________  **Date:** ____________________________

1. **Have you ever had a Bone Density or DEXA scan?**  
   - Y  - N

2. **Have you been diagnosed with osteoporosis or osteopenia?**  
   - Y  - N

3. **Are you on or have you been on an osteoporosis medicine?**  
   - Y  - N
   
   **If yes, which one and for how long?** ____________________________

4. **Are you Asian or Caucasian (white) and over 50 years old?**  
   - Y  - N

5. **Have you ever broken a bone easily or with a minor fall?**  
   - Y  - N

6. **Have you had a recent fracture, including vertebral fracture?**  
   - Y  - N

7. **Are you postmenopausal or have you had a hysterectomy?**  
   - Y  - N  - N/A

8. **Are you a current smoker or use tobacco?**  
   - Y  - N

9. **Do you have more than 3 alcoholic drinks per day?**  
   - Y  - N

10. **Do you avoid dairy products in your diet?**  
    - Y  - N

11. **Do you spend less than 10 minutes a day outdoors?**  
    - Y  - N

12. **Have you ever been told by a doctor that you are underweight?**  
    - Y  - N

13. **Do you take prednisone or other glucocorticoids?**  
    - Y  - N

14. **Have either of your parents been diagnosed with osteoporosis?**  
    - Y  - N

**If you circled YES to 3 or more of these questions, you may be at risk for osteoporosis.**

Call for an appointment at the Bone Health Clinic:  
Friday ________________ at ________________ a.m.

Please bring this completed form with you to your appointment.