Orthopaedics of Brevard

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Osteoporosis Risk Assessment Form

Date: _________________________

Patient Name (print): ____

Date of Birth: ________________________ Age: __________ Gender: ________

Have you ever had a bone density study? ________ If yes, date: ______________

Name of primary care physician: ____

Women only – Gynecologic History

- Is (was) your menstruation cycle regular between 18-40 years? ❑ Yes ❑ No ❑ Unsure
- Did you have intervals with few or no bleeding cycles other that during a pregnancy?
  Age: ____________ Length of time: ______________
- Have you had a hysterectomy? If yes what year: __________ ❑ Yes ❑ No ❑ Unsure
- If hysterectomy performed were ovaries removed? ❑ Yes ❑ No ❑ Unsure
- Have you entered menopause? If yes what year: __________ ❑ Yes ❑ No ❑ Unsure

Medications

- Are you currently taking hormone replacement pills or patches? ❑ Yes ❑ No ❑ Unsure
- Do you currently take cortisone, prednisone, or steroids? ❑ Yes ❑ No ❑ Unsure
- Do you ever take sleeping pills? If yes how often: __________ ❑ Yes ❑ No ❑ Unsure

Lifestyle

- Do you currently take thyroid medication? ❑ Yes ❑ No ❑ Unsure
- Do you smoke cigarettes? Packs/day: __________ ❑ Yes ❑ No ❑ Unsure
- Do you drink alcoholic beverages? Drinks/day: __________ ❑ Yes ❑ No ❑ Unsure
- Do you drink beverages with caffeine (coffee, tea, soda)? ❑ Yes ❑ No ❑ Unsure
  Amount of caffeinated beverages/day: __________
- Do you exercise regularly? Amount/day: __________ ❑ Yes ❑ No ❑ Unsure

Fracture and falls

- Have you ever broken any bones? ❑ Yes ❑ No ❑ Unsure
  Year(s): ________________________ Site(s): _______________________
  How: ____

History of osteoporosis and back pain

- Does anyone in your immediate family have osteoporosis? ❑ Yes ❑ No ❑ Unsure
  ❑ Mother ❑ Father ❑ Sister(s) ❑ Brother(s) ❑ Grandmother ❑ Grandfather
- Do you ever have back pain? ❑ Yes ❑ No ❑ Unsure
  Check applicable: ❑ Mild ❑ Severe ❑ Dull ❑ Sharp ❑ Intermittent ❑ Constant