

Spiddal Medical Centre Dxa Questionnaire

Name: _____

Date of Birth: _____

Address: _____

Landline: _____ Mobile: _____

Email: _____

(please ensure you provide an email if possible)

Consent to contact you via SMS & email and attachments? Yes No

GP Name & Address: _____

Is there a family history of osteoporosis? Yes No

Have you previously broken a bone? Yes No

Did either of your parents ever fracture a hip? Yes No

Do you currently smoke? Yes No

Have you ever taken oral steroids (Prednisolone) Yes No

If so for how long? _____

Do you have any of the following:

Insulin Dependent Diabetes Yes No

Overactive Thyroid Yes No

Crohns/Ulcerative Colitis/Coeliac Yes No

Have you confirmed Rheumatoid Arthritis? Yes No

Do you drink: Beer/Wine/Spirits Yes No
How much? _____

Are you on any medication for your bones? Yes No

Please specify

Fosamax/Fosavance/Actonel/Protelos

Calcium Supplement

Prolia Injection

Did you go through the menopause before the age of 45? Yes No

Did you have a hysterectomy or your ovaries removed? Yes No

Did your periods stop for more than 6 months at any stage apart from when you were pregnant or the menopause? Yes No

Date of last period _____

How many pregnancies have you had? _____

Are you currently pregnant? Yes No

Have you had a barium meal/enema or intravenous Pyleogram in the last week? Yes No

Signed: _____ Date: _____