Irish Osteoporosis Society

BONE MINERAL DENSITY QUESTIONNAIRE - MALE

This questionnaire consists of **FOUR** pages. Please answer **ALL** questions.

Patients Details

Date: / /

Name:

Address:

Telephone: Mobile:

Doctors Name:

Sex: M ☐ F ☐ Age: Date of Birth:

Height: Weight:

Occupation:

Why are you having a Dexa Scan?

Social Status: Med. Card Non-Med Card

Marital Status:

Have you had any children? Yes ☐ No ☐ How many?

Exercise History

Exercise history now: Type Minutes/Day:

In the past: Type Minutes/Day:

Are you or were you ever a competitive athlete? Yes ☐ No ☐

If yes, at what level?

Do you require dental treatment? Yes ☐ No ☐

Dietary History

Vegetarian: Yes ☐ No ☐ Vegan: Yes ☐ No ☐

How many years? What age did you start?

Was your childhood diet: Good ☐ Bad ☐

Dietary Calcium: Milk: Yes ☐ No ☐ Total milk Per day

If yes, Type: Supermilk ☐ Regular ☐ Low Fat ☐ Soya ☐

Cheese: Per week Yogurt: Per week

Do you eat everything? Yes ☐ No ☐

If no, what do you not eat?

114 Pembroke Road, Garden level, Ballsbridge, Dublin 4

Tel: Lo-Call 1890 252 751/ Tel: 01 637 505 Fax: +353 (0)1 668 0098 Email: info@irishosteoporosis.ie

Irish Osteoporosis Society

BONE MINERAL DENSITY QUESTIONNAIRE - MALE

This questionnaire consists of **FOUR** pages. Please answer **ALL** questions.

Do you have a history of eating disorders: Yes ☐ No ☐

If yes: Anorexia: Yes ☐ No ☐ What age did you start? _____

Bulimia:Yes ☐ No ☐ Frequent Dieting: Yes ☐ No ☐

How much coffee do you drink? Instant _____ Per day Percolated _____ Per day

How much tea do you drink? _____ Per day Weak: Yes ☐ No ☐ Strong: Yes ☐ No ☐

How much water do you drink? _____ Per day

How much alcohol do you drink? _____ Units/week

History of smoking? Yes ☐ No ☐

If yes, what age did you start? _____ Stop? _____

How long? _____ How many a day? _____

Medical History

Do you suffer from?

Varicose veins	Yes ☐	No ☐	Osteoarthritis	Yes ☐	No ☐
Phlebitis	Yes ☐	No ☐	Blood Disease	Yes ☐	No ☐
Deep Vein Thrombosis	Yes ☐	No ☐	Haemachromatosis	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Migraine	Yes ☐	No ☐
Type: _____			Hypertension	Yes ☐	No ☐
Radiation	Yes ☐	No ☐	Asthma	Yes ☐	No ☐
Chemotherapy	Yes ☐	No ☐	Hyperparathyroidism (Kidney Stones)		
Rheumatoid Arthritis	Yes ☐	No ☐		Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Hiatus Hernia	Yes ☐	No ☐
Type: _____			Gastric Ulcer	Yes ☐	No ☐
Thyroid Disease	Yes ☐	No ☐	Liver Disease	Yes ☐	No ☐
High Cholesterol	Yes ☐	No ☐	Kidney Disease	Yes ☐	No ☐
Bloating of stomach after food	Yes ☐	No ☐	Hypogonadism	Yes ☐	No ☐
Constipation	Yes ☐	No ☐	Transplant	Yes ☐	No ☐
Diarrhoea	Yes ☐	No ☐	Depression	Yes ☐	No ☐
Malabsorption	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐
Coeliac	Yes ☐	No ☐	Stroke	Yes ☐	No ☐

Have you had excessive stress? Yes ☐ No ☐

Have you had surgery? Yes ☐ No ☐

If yes, what type and year? _____ /_____

Have you had a serious illness? Yes ☐ No ☐

If yes, what type and year? _____ /_____

Have you had a testes removed? Yes ☐ No ☐

have you had mumps after puberty? Yes ☐ No ☐

Irish Osteoporosis Society

BONE MINERAL DENSITY QUESTIONNAIRE - MALE

This questionnaire consists of **FOUR** pages. Please answer **ALL** questions.

Have you had loss of libido? (i.e.. No interest in sex) Yes ☐ No ☐
Do you have a family history of prostate cancer? Yes ☐ No ☐
Do you have a family history of heart disease? Yes ☐ No ☐
Do you have a family history of osteoporosis Yes ☐ No ☐
Or any other bone disorder? Yes ☐ No ☐
Do you have a personal history of osteoporosis Yes ☐ No ☐
Or osteopenia? Yes ☐ No ☐
Have you sustained any fractures (broken bone) Yes ☐ No ☐
If yes, what bones _____ What year _____
Low trauma? Yes ☐ No ☐
Have you had a fall or fallen in the last year Yes ☐ No ☐
Have you or are you losing height or developing spinal curvature? Yes ☐ No ☐
Have you had or have back pain? Yes ☐ No ☐

Medication

Are you or have you been on any of the following medications?
Calcium Yes ☐ No ☐
Vitamin D Yes ☐ No ☐
If yes, What prearation and for how long? _____

Vitamins: Yes ☐ No ☐
If yes, Which ones _____
Anticoagulants: Yes ☐ No ☐
Aspirin Yes ☐ No ☐
Warfarin Yes ☐ No ☐
Heparin Yes ☐ No ☐
Other _____
Bisphosphonates Yes ☐ No ☐
If yes, Which and for how long : _____
Actonel Yes ☐ No ☐
Bonviva Yes ☐ No ☐
Fosamax Yes ☐ No ☐
Zolodronic Acid Yes ☐ No ☐
Are you taking Protelos? Yes ☐ No ☐
If yes, Which and for how long : _____

114 Pembroke Road, Garden level, Ballsbridge, Dublin 4
Tel: Lo-Call 1890 252 751/ Tel: 01 637 505 Fax: +353 (0)1 668 0098 Email: info@irishosteoporosis.ie

BONE MINERAL DENSITY QUESTIONNAIRE - MALE

This questionnaire consists of **FOUR** pages. Please answer **ALL** questions.

Are you taking Prolia?	Yes	☐	No	☐		
If yes, how many injections have you had?						
Are you on Forsteo?	Yes	☐	No	☐		
If yes, Which and for how long :						
Anti-convulsive	Yes	☐	No	☐	Which and for how long :	
Glucorticoids	Yes	☐	No	☐	Which and for how long :	
Eltroxin	Yes	☐	No	☐	Which and for how long :	
Contraceptive Pill	Yes	☐	No	☐	Which and for how long :	
Hormone Replacement Therapy	Yes	☐	No	☐	Which and for how long:	
Are you on any other medication?	Yes	☐	No	☐		
If yes, What?						

114 Pembroke Road, Garden level, Ballsbridge, Dublin 4
Tel: Lo-Call 1890 252 751/ Tel: 01 637 505 Fax: +353 (0)1 668 0098 Email: info@irishosteoporosis.ie