PATIENT RISK ASSESSMENT FOR BMD

(Please DO NOT leave any question blank. We are aware that we may have this information in your chart, but are asking that you fill out this form in its entirety for something may have changed, Thank you)

DATE: _____

Patient Name: _____ DOB: _____

PERSONAL HISTORY		DETAILS
Bone loss	YES / NO	_____
Medication for Bone Loss	YES / NO	_____
Steroids	YES / NO	_____
Thyroid Medication	YES / NO	_____
Ovaries Removed	YES / NO	_____
Do you take sleeping pills	YES / NO	_____
History of smoking	YES / NO	_____
Drink alcoholic beverages	YES / NO	_____
Drink Caffeinated	YES / NO	_____
Do you Exercise	YES / NO	_____
Broken any bones as an Adult	YES / NO	_____
Family History of Osteoporosis	YES / NO	_____