



Bone Density Risk Assessment

Date _____

Patient Name (print) _____

Date of Birth _____

Answer the questions by checking the appropriate response (yes, no, don't know) to the right. If your answer is "yes", enter additional information in the box at left.

Table with 4 columns: Question, YES, NO, Don't know. Rows include Gynecologic history (women only), Medications, Lifestyle, Fractures and falls, and History of osteoporosis and back pain.