

CREIGHTON UNIVERSITY
Osteoporosis Research Center
Personal Information Form

Date: _____
(Date of Completion)

Last Name Title / First Name Birthdate (mm/dd/yyyy) Gender

Street City State Zip Code
() Ext () Ext
Phone - Day Phone - Evening

Race: (check one below)
____ American Indian or
____ Alaskan Native
____ Asian or Pacific Islander
____ Black, Not Hispanic
____ Hispanic
____ White, Not Hispanic
____ Other _____
(please specify)

FEMALE HISTORY (Women Only)

1. Have you experienced menopause (no longer have menstruation)? **YES / NO**
2. If YES for menopause, date of your last menstrual period: _____ and type of menopause: Natural ____ Surgical ____
Month and Year (estimate if unsure) (check one)
3. If you have experienced a surgical menopause, were both ovaries removed? **YES / NO**
- | | Start Date | Stop Date |
|---|------------|-----------|
| 4. Are you currently taking estrogen (hormones) for menopause? YES / NO
Please indicate Start and/or Stop Dates for current or past use of estrogen: | _____ | _____ |
| 5. Total years of post-menopausal estrogen use: _____ | | |

MEDICAL HISTORY (Men and Women)

- | | Start Date | Stop Date |
|---|------------|-----------|
| 1. Have you ever taken prescription medication for osteoporosis, such as Fosamax, Calcitonin, Raloxifene, Actonel or Forteo? YES / NO
If YES, Current medication name: _____ | _____ | _____ |
| 2. Any previous use of other prescription medication(s) for osteoporosis? YES / NO
If YES, Previous medication name: _____ | _____ | _____ |
| 3. During the last 6 months have you taken any steroid medications, such as Prednisone, Medrol Dose Pack, or Cortisone (oral, inhaled, or injection)? YES / NO
If YES, medication name: _____ | _____ | _____ |
| 4. Have you ever smoked? If YES, please indicate Start and/or Stop Dates: YES / NO
If YES, For how many years? _____ How many packs/day? _____ | _____ | _____ |
| 5. Have you ever had a fracture(s) or broken bone(s) (e.g. wrist, hip, leg, arm)? YES / NO If Yes, Please list all below
Bone Broken / Fracture Date Bone Broken / Fracture Date Bone Broken / Fracture Date Bone Broken / Fracture Date
_____/_____/_____/_____/_____/_____/_____/_____ | | |
| 6. Have you ever had any history of cancer, other than basal cell skin cancer? YES / NO
If YES, Type of Cancer: _____ Date of Diagnosis: _____ | | |
| 7. Your current Height: _____ (inches) Your current Weight: _____ (lbs.) | | |

By signing this form, I give Creighton University Osteoporosis Research Center (ORC) permission to add the above information into its confidential database files so that I may be contacted for future research opportunities at the ORC, provided the Creighton University Institutional Review Board approves such access and uses. This authorization has no expiration date.

Print Your Name: _____ Your Signature: _____ This Date: _____