## PATIENT INFORMATION

Name: Patient ID

Menopause Age: \_\_\_\_ Height:(in) \_\_\_\_ Weight:(ib) \_\_\_\_ Gender: Q M Q F Date of Birth Ethnicity: \_\_\_\_ Referring Physician:

- 3. Did either of your parents ever have a hip fracture.
- 4. Do you smoke?
- 5. Have you ever taken Glucocorticoids?
- 6.