OStEO Observational Study Examining Osteoporosis

University Hospital Southampton NHS
NHS Foundation Trust
UNIVERSITY OF Southampton

Investigating Fracture and Osteoporosis

Chief Investigator: Dr Philipp Thurner, Faculty of Engineering and the Environment, University of Southampton, SO17 1BJ Email: osteo@soton.ac.uk

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Assessment Form

Version 2.0 (26/11/12)

Questionnaire to be completed in a researcher lead session. Any relevant details that are available in the medical notes should be used to complete any incomplete or uncertain questions (focussing on those marked with *To be completed with aid of the medical notes*).

 # Indicates information to be used for FRAX calculation

To be completed by the researcher

Participant ID:

Date of Birth:

SECTION ONE: FALLS AND INJURIES

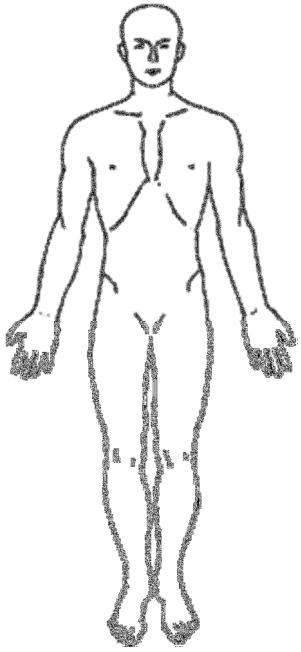
Q1 Have you had any serious falls since the age of 45? No ☐ Yes ☐

a At what age did you first fall? ☐☐

b How many falls have you had in the last year? No ☐ Yes ☐

**c** Is this your first broken bone? No ☐ Yes ☐

d Please mark on the drawing the location of any other broken bone(s) indicating the age at which you broke the bone(s) and annotating with the name of the bone(s) if known.



e How did you break bone? High trauma (fall from greater than standing height, car accident etc) ☐ Low trauma (fall from standing height or less) ☐

**f** Did either of your parents have a hip fracture? (if known) No ☐ Yes ☐

SECTION TWO: GENERAL WELL-BEING AND MEDICATION

Q2 Have the following issues started or become worse in the last year? Do you think any of these issues have caused a fall (particularly in those falls that a bone was broken)?

	Unchanged = 0 Worsened = 1	Cause a fall? No = 0, Yes = 1
i) Sudden loss of balance?	☐	☐
ii) Weakness in the arms or legs?	☐	☐
iii) Dizziness when standing up quickly?	☐	☐
iv) Unexplained weight loss?	☐	☐
v) Sudden attack of vision loss or blurred vision in one or both eyes?	☐	☐

 # d Have you ever had a diagnosis of rheumatoid arthritis? No ☐ Yes ☐

 # e Have you ever taken glucocorticoids? (greater than 5mg taken orally daily for more than 3 months) No ☐ Yes ☐

 # f Do you currently have any of the following disorders?

1 Type 1 (insulin dependent) diabetes	No ☐	Yes ☐
2 Type 2 (non-insulin dependent) diabetes	No ☐	Yes ☐
3 Osteogenisis Imperfecta (brittle bone disease)	No ☐	Yes ☐
4 Hyperparathyroidism	No ☐	Yes ☐
5 Hyperthyroidism (longstanding and untreated)	No ☐	Yes ☐
6 Hypogonadism or early menopause (before 45)	No ☐	Yes ☐
7 Chronic malnutrition or chronic liver disease	No ☐	Yes ☐

Q3a Have you had a previous diagnosis of Osteoporosis? No ☐ Yes ☐

To be completed with aid of the medical notes

b Do you currently or have you ever taken any medication for osteoporosis?

	Ever taken? (Yes – 1, No – 0)	Number of years and months taken for (yy.mm)	Currently taking? (Yes – 1, No – 0)	Number of years and months since last taken (yy.mm)
Alendronate				
Risedronate				
Raloxifene				
Denosumab				
Parathyroid Hormone				
Zolendronate				
Ibandronate				
Strontium Ralenate				
Other (please specify) _____				

c Do you currently taken any other medications? What conditions are these for?

Name of Medication	Reason for taking medication
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____
13. _____	_____
14. _____	_____
15. _____	_____

Q4 EQ- 5D Quality of Life Assessment Tool

By placing a tick in one box in each group below, please indicate which statements best describe your own health state before you broke this bone.

Mobility

I have no problems in walking about ❑
I have some problems in walking about ❑
I am confined to bed ❑

Self-Care

I have no problems with self-care ❑
I have some problems washing or dressing myself ❑
I am unable to wash or dress myself ❑

Usual Activities (*e.g. work, study, housework, family or leisure activities)*

I have no problems with performing my usual activities ❑
I have some problems with performing my usual activities ❑
I am unable to perform my usual activities ❑

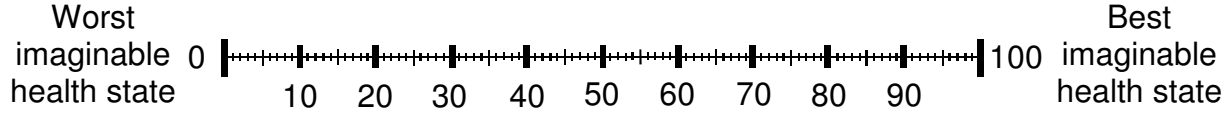
Pain/Discomfort

I have no pain or discomfort ❑
I have moderate pain or discomfort ❑
I have extreme pain or discomfort ❑

Anxiety/Depression

I am not anxious or depressed ❑
I am moderately anxious or depressed ❑
I am extremely anxious or depressed ❑

The scale below starts at 0, which is the worst health state you can imagine, and goes up to 100, which is the best health state you can imagine. We would like you to indicate on the scale how good or bad, in your own opinion, your own health was before you broke this bone.



SECTION THREE: SOCIAL

Q5a Have you ever smoked regularly? (i.e. at least once a day for a year or more) No ☐ Yes ☐

If no, Go to Q6

 # b Do you still smoke regularly? No ☐ Yes ☐

c How old were you when you last smoked regularly? ☐☐

d Typically, how much do you smoke now?

Cigarettes/week ☐☐☐

Roll-up tobacco (per oz)	equivalent ~ 50 cigarettes
Cigars (1 cigar)	equivalent ~ 2 – 4 cigarettes
Pipe tobacco (per oz)	equivalent ~ 30 cigarettes

Q6 a Do you ever drink alcohol? No ☐ Yes ☐

If no, Go to Q7

 # b How many units do you normally drink per week? ☐☐

beer/cider	2 – 3 units per pint
wine (~12%)	1.5 units per small glass
	2 units per medium glass
	3 units per large glass
fortified wine (e.g. sherry/port ~ 20%)	1 unit per measure (50 ml)
spirits (~40%)	1 unit per single (25 ml) measure

SECTION FOUR: PHYSICAL ACTIVITY

Q7 a On a typical day how long would you spend walking (in hours and minutes)? ☐☐

b How much time do you spend on exercise or physical activity in a typical week (give in approximate number of hours)? e.g. gardening, housework, exercise ☐

SECTION FIVE: OESTROGEN

WOMEN ONLY. For men go to Q9

Q8 a At what age did your periods stop? ☐☐

To be completed with aid of the medical notes

b Have you had a hysterectomy (removal of the womb)?

No ☐ Yes ☐

c ***If yes*** how old were you? ☐☐

d Did the hysterectomy include removal of the ovaries?

No ☐ Yes ☐ Don't Know ☐

e Have you ever taken hormone replacement therapy?

No ☐ Yes ☐

f ***If yes,*** at what age did you start? ☐☐

g How long in total did you take it for (months)? ☐☐

h Have you ever taken an oral contraceptive pill?

No ☐ Yes ☐

i ***If yes,*** How long in total did you take it for (years and months)?

☐☐ Years ☐☐ Months

SECTION SIX: DIETARY

Q9 a In a normal day, how many units of calcium do you consume? ☐☐

1 glass of milk (250 ml)	1 unit per glass 0.5 units in cereal, 0.1 units in hot drinks
1 pot of yoghurt (150 ml)	1 unit per pot
Ice cream, cream, custard etc	0.5 units per serving
Cheese (25 g serving)	0.5 units per serving
Green vegetables	0.5 units per serving
Oily Fish (mackerel, sardines)	0.5 units per serving
Slice of bread/cake	0.5 units per slice

b Do you take any calcium supplements? No ☐ Yes ☐
If no, Go to Q10

c How long have you been taking them? ☐ months

d How many do you take per day? ☐

e What is the name of the supplement? _____

Q10 a Do you take any vitamin D supplement? No ☐ Yes ☐

If no, Go to Q11

b How long have you been taking them ☐ months

c How many do you take per day? ☐

d What is the name of the supplement? _____

To be completed with aid of the medical notes

e Vitamin D level (25 hydroxy vitamin D level in ng/ml) ☐

Q11 a In a normal day, how many units of caffeine do you drink? ☐☐

1 cup of coffee	0.5 unit per small cup (single espresso) 1 unit per regular cup (double espresso) 2 units per large cup
1 cup of decaffeinated coffee	0 units per cup
1 cup of tea	0.5 units per regular cup
Caffeinated soft drinks (e.g. cola)	0.5 unit per can or small glass (~ 330 ml) 1 unit per bottle or large glass (~ 500 ml)
1 can of energy drinks	1 – 2 units per can (~ 250 ml)