

Patient name: _____

Date of birth: _____
(or affix label here)

Historical height (cm)^C: _____

Prospective height (cm)^C: _____

Osteoporosis Medications		
<input type="checkbox"/> calcium (1500 mg/day) or _____		
<input type="checkbox"/> vitamin D (800 IU/day) or _____		
Drug & Dose	Date Started	Date Stopped

VISIT DATE						
AGE (YR) ^A						
WEIGHT (KG) ^B						
HEIGHT (CM) ^C						
BMI (KG/M ²) ^B						
BLOOD PRESSURE ^D	Supine/Sitting					
	Standing					
LOSS OF HEIGHT, KYPHOSIS, OR BACK PAIN ^E	(Y/N)					
RISK FACTORS ^F	(Reviewed; Y/N)					
	(Check list on reverse)					
RISK OF FALLING ^D	(Reviewed; Y/N)					
BMD RESULTS ^G						
(T-SCORES)	- 0.5					
	- 1.0					
	- 1.5					
■ lumbar spine (L1 - L4)	- 2.0					
● femur (Hip total)	- 2.5					
	- 3.0					
10YEAR AFR ^H	(low/med/high)					
COUNSELLING ^I	(Reviewed; Y/N)					
	Diet					
	Activity					
	Lifestyle					

- Notes ^{1,2,3}
- A **Age:** All men over the age of 50 should be assessed for their osteoporosis risk factors. Men older than 65 should be screened for osteoporosis by bone mineral density (BMD) testing every 1 to 2 years. Less frequent screening is needed if previous BMDs were normal.
 - B **Weight and body mass index (BMI):** a BMI of ≤ 20 kg/m² is associated with decreased bone density and an increased risk of fracture.
 - C **Height:** Historical height refers to a maximum "recalled" height. Prospective height refers to a recorded maximum height over the past 3 years. A 4 cm historical height loss or a 2 cm prospective height loss should warrant investigations for potential vertebral fractures. Precise measurement of height is very important.
 - D **Blood pressure and risk of falling:** Falls are a significant cause of fractures and patient's risk of falling should be regularly assessed. This includes asking men about their past history of falls, current medications (especially sedatives and alcohol), and any environment hazards in their homes. Physical examination should include monitoring for orthostatic blood pressure changes, assessing gait and balance, and checking vision and hearing. If there are concerns, a proper falls assessment should be arranged.
 - E **Loss of height, kyphosis, or back pain:** These symptoms should alert clinicians to the possibility of vertebral compression fractures. Radiographic investigations are then warranted to rule out fractures.
 - F **Risk factors:** Risk factors help to assess a man's risk of osteoporosis and determines whether they require further assessment and treatment. Risk factors are displayed on the reverse side.
 - G **BMD results:** The World Health Organization (WHO) classifies T-score results as follows: normal ≥ -1.0 ; osteopenia (low bone mass) between -1.0 and -2.5; osteoporosis ≤ -2.5 ; severe osteoporosis ≤ -2.5 plus fragility fracture (low trauma fracture). Plot patient's BMD results to monitor trends.
 - H **Ten year absolute fracture risk (AFR):** This score utilizes both BMD and clinical factors to determine a man's future risk of fracture. Calculating the 10 year AFR is outlined on the reverse side. This prediction only applies for a finite period of time.
 - I **Counselling tips:** Don't forget to discuss the following with your patient: Adherence to non-pharmacological treatments is very important and should be constantly reinforced.
 - Diet: Ensure adequate levels of calcium and vitamin D (vitamin D3, or cholecalciferol is preferred over vitamin D2, or ergocalciferol). Recommended daily intake for men is 1500 mg of calcium (in 3 divided doses with meal) and 800 IU of vitamin D.
 - Activity: 30 minutes or more of weight bearing physical activity (eg. walking) is recommended at least 3 times a week.
 - Lifestyle: Encourage smoking cessation (smoking lowers bone mass) and limit alcohol consumption.

