



Participant ID: _____

Participant Initials: _____

Clinical Center: _____

Site: _____

Visit Number: _____

CRF Date: _____

RC ID: _____

FRACTURE QUESTIONNAIRE
(Collected in all participants at Phase III Entry)

1. Did you ever have a confirmed broken or fractured bone after you turned 35 years old? ₁ Yes ₀ No ₈₈ Don't Know ₉₉ N/A

If **“Yes”** to Question #1, please indicate which bone(s) you broke, and how old you were when this occurred.

Which bone(s) did you break?

Age when first broken
(a)

- | | | |
|-----------------------------|--|-------------|
| 2. Hip/pelvis | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No | _____ years |
| 3. Upper leg (femur) | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No | _____ years |
| 4. Lower leg (tibia/fibula) | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No | _____ years |
| 5. Ankle | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No | _____ years |
| 6. Foot/toes | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No | _____ years |
| 7. Hand/fingers | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No | _____ years |
| 8. Wrist | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No | _____ years |
| 9. Upper arm (humerus) | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No | _____ years |
| 10. Lower arm (radius/ulna) | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No | _____ years |
| 11. Spine (vertebra) | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No | _____ years |
| 12. Other (Specify: _____) | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No | _____ years |