

BONE DENSITY QUESTIONNAIRE



NAME: _____ Age: _____

DATE OF BIRTH: _____ MENOPAUSAL AGE: _____ MALE / FEMALE

RACE: CAUCASIAN / ASIAN / AFRICAN AMERICAN / HISPANIC

ORDERING PHYSICIAN: _____

INDICATION FOR STUDY: _____

Have you ever had a bone density study before? YES _____ NO _____

When? _____ Where? _____

Have you ever had a previous hip or spine fracture? YES _____ NO _____

Have you had any fractures during your adult life which did not result from significant trauma(e.g. car accident)? YES _____ NO _____

Did either of your parents have a hip fracture? YES _____ NO _____

Do you smoke? YES _____ NO _____

Are you currently taking or have you previously taken Prednisone Pills? YES _____ NO _____

Currently _____ For how long? _____ What is your dosage? _____ Yes, previously _____

Do you drink 3 or more alcoholic drinks per day? YES _____ NO _____

Are you being treated for Osteoporosis? YES _____ NO _____

Does a parent or sibling have Osteoporosis?
YES _____ NO _____

ARE YOU CURRENTLY OR HAVE YOU EVER TAKEN ANY OF THE FOLLOWING MEDICATIONS?

MEDICATION	PAST	CURRENTLY	FOR HOW LONG
Actonel / Atelvia (risedronate)			
Miacalcin (calcitonin)			
Forteo (parathyroid hormone)			
Evista (raloxifene)			
Fosamax (alendronate)			
Reclast (zoledronate)			
HRT (estrogen / hormone therapy)			
Boniva (ibandronate)			
Prolia (denosumab)			
Aredia (pamidronate)			
Testosterone (Lupron)			
Vitamin D			
Calcium			
Acid Reflux Medications			

PLEASE LIST YOUR CURRENT MEDICATIONS:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

**Anorexia or Bulimia
Hyperparathyroidism
Cancer**

**Asthma or emphysema
Seizure disorders
Type I diabetes**

**End stage renal disease
Inflammatory bowel disease
Rheumatoid Arthritis**

What was your maximum height?

Do you perform exercise regularly?

YES _____ NO _____

Do you regularly consume dairy products?

YES _____ NO _____

Do you drink caffeinated beverages?

YES _____ NO _____

Do you have frequent falls or loss of balance?

YES _____ NO _____

Have you ever had kidney stones?

YES _____ NO _____

Have you ever had weight loss surgery?

YES _____ NO _____

Have you ever had surgery of the spine, hips, legs or arms?

YES _____ NO _____

Do you have any swallowing problems or suffer from heartburn?

YES _____ NO _____

Have you ever been told you have arthritis of the spine?

YES _____ NO _____

Have you ever been told you have scoliosis of the spine?

YES _____ NO _____

Have you had any major dental issues?

YES _____ NO _____

IF FEMALE:

Are you pregnant?

YES _____ NO _____

Are you premenopausal?

YES _____ NO _____

At what age did your periods start?

How many full term pregnancies have you had?

**Have you ever missed your period for more than 6 months in a row?
Not including pregnancy or menopause.**

YES _____ NO _____

Have you had a hysterectomy?

YES _____ NO _____

Was it a partial _____ or total _____?

At what age? _____