

PLACE LABEL HERE

BONE DENSITOMETRY QUESTIONNAIRE

Please complete the following questions to the best of your ability. If you are unsure of an answer leave the space blank. All answers will be kept in strict confidence and treated as information in your medical record.

Ethnicity: (Please circle one) African American Caucasian Hispanic Asian

Height: _____ Weight: _____

Please circle YES, NO, or Unsure:

Have you had a bone density before? YES NO UNSURE

Have you noticed a loss of height? YES NO UNSURE

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

Does anyone in your family have osteoporosis? YES NO UNSURE

Are you taking a calcium supplement daily? YES NO UNSURE

Does your calcium supplement contain Vitamin D? YES NO UNSURE

Have you had any recent studies that required contrast such as "X-Ray Dye" or "Barium" YES NO UNSURE

Do you have a history of any back or hip surgery? YES NO UNSURE

If YES, did you have a hip replacement or screw in hip? YES NO UNSURE

Have you completed menopause? YES NO UNSURE

If yes, at what age? _____

Have you fractured any of the following bones in your adult life? (Please Circle)

Spine Pelvis Hip Feet Wrist Forearm Humerus (upper arm)

Have you taken or are you taking any of the following medications?

____ Fosamax or Actonel ____ Miacalcin (Calcitonin) ____ Thyroid Medication ____ Forteo

____ Anticonvulsants (medication for seizure disorder) ____ Hormone Replacement (HRT or ERT)

____ Evista (Raloxifene) ____ Prolia ____ Steroids (Cortisone, Prednisone, etc.) for more than 3 months at a dose of 5mg daily or greater

Do you smoke cigarettes? YES NO If yes, how many daily? _____

If you have quit smoking, how many cigarettes did you smoke daily? _____

Does your regular exercise include weight resistance or lifting weights? _____

Have you ever been diagnosed with either of the following:

____ Rheumatoid Arthritis or ____ Secondary Osteoporosis (Type I – insulin dependent Diabetes, Chronic Liver Disease, Chronic Malabsorption or Untreated Hyperthyroidism) or _____ Prostate Cancer

Signature: _____

Date: _____

Technologist initials: _____

Date: _____