BONE DENSITOMETRY PATIENT QUESTIONNAIRE

NAME: _____DATE: _____

DATE OF BIRTH: _____MALE ___ FEMALE ___ PHYSICIAN_____

RACE: CAUCASIAN _____ AFRICAN-AMERICAN _____ HISPANIC _____ ASIAN _____ OTHER _____

HEIGHT: _____ WEIGHT: _____

HAVE YOU HAD A DEXA SCAN BEFORE? Y N (CIRCLE)

IF THE ANSWER IS YES: WHEN? _____ WHERE? _____

IS THERE A FAMILY HISTORY OF OSTEOPOROSIS? _____

FOR FEMALE PATIENTS ONLY

ARE YOU STILL HAVING A MENSTRUAL PERIOD? _____ IF NO, AT WHAT AGE DID YOU START MENOPAUSE? _____

HAVE YOU HAD A HYSTERECTOMY? _____ DO YOU STILL HAVE YOUR OVARIES? _____

ARE YOU CURRENTLY TAKING HORMONES? _____ IF YES, WHAT HOROMONES ARE YOU TAKING AND FOR HOW LONG? _____

FOR MALE PATIENTS ONLY

DO YOU HAVE HYPOGONADISM? _____ DO YOU HAVE LOW TESTOSTERONE? _____

HAVE YOU EVER HAD A COMPRESSION FRACTURE OF THE SPINE? _____

HAVE YOU EVER HAD ANY SURGERY OR FRACTURES IN THE FOLLOWING AREAS?

1. SPINE: _____WHEN? _____
2. HIPS: _____ WHEN? _____
3. WRIST:_____ WHEN? _____
4. FOREARM:_____ WHEN? _____

DO YOU SMOKE? _____ IF SO, HOW MUCH? _____

DO YOU CONSUME ALCOHOLIC BEVERAGES? _____ IF SO, HOW MUCH? _____

DO YOU TAKE CALCIUM SUPPLEMENTS DAILY? _____ IF SO, HOW MUCH? _____

DO YOU TAKE VITAMIN D SUPPLEMENTS? _____ IF SO, HOW MUCH? _____

HAVE YOU EVER TAKEN ANY OF THE FOLLOWING MEDICATIONS ROUTINELY AND IF SO, FOR HOW LONG:

1. STEROIDS (PREDNISONE, CORTISONE, ETC) _____
2. THYROID MEDICATIONS _____
3. ANTICONVULSANTS (FOR SEIZURES) _____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

1. OSTEOPOROSIS: _____ IF YES, WHEN/WHAT MEDICATIONS?_____
2. HYPERPARATHYROIDISM: _____ 5. KIDNEY DISEASE: _____
3. HYPERTHYROID: _____ 6. PART OF STOMACH REMOVED: _____
4. INTESTINAL/BOWEL DISEASE: _____ 7. ANY TYPE OF ARTHRITIS: _____