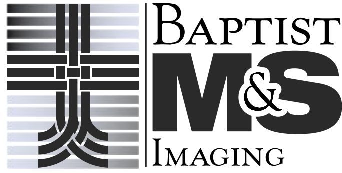
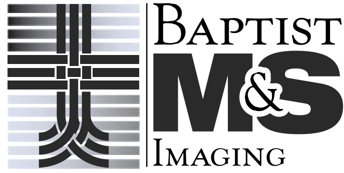


BONE DENSITOMETRY QUESTIONNAIRE

Patient Name: ______________________________________ Last 4 numbers of SS#: ____________________
Referring Physician: __________________________________ Next Appointment Date: ____________________
Weight: ______ Height: ______ Date of Birth: _____ / _____ / ____ Ethnicity: Sex: ❑ Male ❑ Female
❑ Asian ❑ Black ❑ Hispanic ❑ White ❑ Other:

CHECK THE ANSWER FOR THE FOLLOWING QUESTIONS

1. Have you ever had a bone density scan before? ❑ Yes ❑ No
   If yes, where and when? ____
2. Have you had hip surgery? ❑ Yes ❑ No ❑ Left ❑ Right
3. Have you had lower back/lumbar surgery? ❑ Yes ❑ No
4. Do you have metal in your hip or back? ❑ Yes ❑ No
5. Have you had cement injected into your spine (vertebroplasty)? __________
6. Have you fractured any bones **after the age of forty**? ❑ Yes ❑ No
   What bone(s): _______________________________
   Was the break due to major trauma (like a car accident) ______ or a simple fall or bump? _____
7. Have you noticed a decrease in your height? ❑ Yes ❑ No
   Maximum height as young adult: _________
8. Does your family have a history of osteoporosis? ❑ Yes ❑ No
9. Did either of your parents fracture their hip? ❑ Yes ❑ No
10. Do you smoke tobacco? ❑ Yes ❑ No
11. Do you drink 3 or more alcoholic beverages daily? ❑ Yes ❑ No
12. Have you been treated with steroids (eg. Prednisone or cortisone) at least 5 mg/day for 3 months?
    No ____________________
    Yes ____________________ Dose: ______________ How long were you treated? ____________________
13. Do you have or have you ever had any of the following conditions?
    - ❑ Hyperparathyroidism or high level of calcium in your blood?
    - ❑ Type I juvenile onset diabetes
    - ❑ Cirrhosis of liver
    - ❑ Part of stomach removed
    - ❑ Bariatric Surgery or gastroplasty for weight loss
    - ❑ Intestinal or bowel disease (celiac disease or Crohn's)
    - ❑ Rheumatoid Arthritis: medication____________, Rheumatologist_____________
    - ❑ Cancer: type__________________



14. Have you ever taken any of the following medications?

Currently	Previously	
❑	❑	Calcium Supplement
❑	❑	Vitamin D
❑	❑	Estrogen
❑	❑	Alendronate (Fosamax and Binosto)
❑	❑	Ibandronate (Boniva)
❑	❑	Zolendronic acid (Reclast and Zometa)
❑	❑	Risedronate (Actonel and Atelvia)
❑	❑	Raloxifene (Evista)
❑	❑	Tamoxifen
❑	❑	Denosumab (Prolia)
❑	❑	Anastozole (Arimidex)
❑	❑	Letozole (Femara)
❑	❑	Exemestane (Aromasin)
❑	❑	Leuprolide (Lupron)
❑	❑	LHRH Agonist (Degarelix)
❑	❑	Testosterone
❑	❑	Goserelin (Zoladex)
❑	❑	Miacalcin (calcitonin)
❑	❑	Teraparatide, parathyroid hormone, PTH (Forteo)
❑	❑	Anti-seizure medication (Dilantin)
❑	❑	Other chemotherapy not listed above
❑	❑	Proton pump inhibitors for gastric reflux (Nexium, Prevacid)

Length of treatment___________________________

REMAINING QUESTIONS **FOR WOMEN ONLY**

1. Have you gone through menopause? ❑ Yes ❑ No
   If **yes**, at what age? __________________
2. Has your uterus been removed? ❑ Yes ❑ No
3. Have both of your ovaries been removed? ❑ Yes ❑ No
   If yes, how old were you? ___________________________
4. Are you taking hormones? ❑ Yes ❑ No

Patient Signature: ____ Date: ________________

Staff Signature: ____ Date: ________________