Partners In Women's Health

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BONE DENSITY QUESTIONNAIRE

Date : _____

Patient Name: (print) _____ Gender: F / M Height _____ Weight _____

Referring Provider: _____ DOB: _____ Age: _____

African American { } Asian { } Caucasian { } Hispanic { } Native American { } Other { }_____

Have you had previous bone density studies? Y / N
If yes, when? _____ Where (if not here)?_____

CIRCLE ONE: Y (yes) or N (no)

Have you had:

Height loss? Y / N
Hip replacement? Y / N If yes: Right / Left / Both (Please circle)
Back surgery? Y / N
If yes, please describe and include if any hardware placed is lumbar: _____
_____
Any fractures during your **adult** life? Y / N
If yes, please indicate site(s) of fracture and cause: _____
Due to trauma and/or motor vehicle accident? Y / N
Low dietary calcium intake (lifelong)? Y / N

What do you consider your age of menopause to be? (when you were 1 year without menstruation): _____
Have you had any other prolonged (>1 year) period of time that your menstrual cycle stopped? Y / N
Do you have a parent with a history of a hip fracture? Y / N
Do you currently smoke? Y / N Have you smoked in the past? Y / N

CONTINUED ON THE OTHER SIDE

Do you take a calcium supplement daily? Y / N
If so, how much? _____ mg/day
Calcium citrate **OR** Calcium carbonate **(CIRCLE ONE)**
Do you take vitamin D3? Y / N How much? _____i.u.
Do you exercise regularly? Y / N Weight bearing? Describe: _____
Do you exercise infrequently or not at all? Y / N
Do you drink **more** than three alcoholic beverages per day? Y / N
Do you drink **more** than two caffeinated beverages per day? Y / N

Have you had any of the following conditions or surgeries:

- **Hyperthyroidism or Hyperparathyroidism** (Not Hypo)? **Y / N**
- Kidney disease? Y / N
- Rheumatoid Arthritis? Y / N
- Eating disorders (anorexia nervosa, bulimia, etc)? Y / N
- Ovaries removed? Y / N Your age at the time of removal: _____
  If yes: Both / Right / Left **(Please circle one)**

Are you currently taking any of the following medications or treatments?

- Steroids (prednisone, cortisone, etc.) Y / N
- Thyroid medication Y / N
- Anticonvulsants (for seizures, epilepsy, etc.) Y / N
- Hormone Replacement Therapy Y / N
- Birth Control Y / N
- Other vitamins
  - List: _____

Have you been given a previous diagnosis of osteopenia? Y / N ….osteoporosis? Y / N

*Are you **currently** on medication for the treatment of osteoporosis?* Y / N
If yes, how long have you been taking? _____

Which one? Actonel { } Boniva, oral { } Boniva, injectable { } Evista { } Forteo { }
Fosamax/Alendronate { } Prolia { } Reclast { } Evenity { } Other { } _____

***Have you had any studies using IV contrast dye within the past 72 hours*?** Y / N

Do you have an umbilical body piercing? Y / N ***(This will interfere with the AP Spine measurement)***
If yes, is it removable? Y / N ***(Please remove prior to scan, if able)***

Thank you for providing us with the necessary information that will enable us to properly evaluate your bone density study today. Please return this questionnaire to the receptionist and our technician will be with you shortly.

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