BONE DENSITY QUESTIONNAIRE

Name _____ **Date** _____ ☐ **Female** ☐ **Male** **Age** _____

Weight _____ Mature Adult Height_____ Present Height _____

Ethnic Group: ☐ Caucasian ☐ Black ☐ Asian ☐ Hispanic ☐ Other_____

	YES	NO
Is there a chance that you are pregnant?	☐	☐
Contrast Studies in the last 2 weeks (Barium, CT, PET, Nuc Med, MRI)?	☐	☐
Have you ever had a bone density test?	☐	☐
Have you ever broken any bones as an adult?	☐	☐
If yes, Which bones_____ Date _____ How did it happen_____		
Have you ever had surgery of the spine (Low/Mid/Upper Back)?	☐	☐
Have you ever had surgery of the hips (Right or Left)?	☐	☐
Have you ever had Vertebroplasty or Kyphoplasty?	☐	☐
Are you currently a smoker?	☐	☐
Do you consume 3 or more alcoholic beverages per day?	☐	☐
Did your biological Father or Mother fracture their hip?	☐	☐

☐ Right-Handed ☐ Left-Handed

Have you ever been diagnosed with or had:

☐ Osteopenia/Osteoporosis ☐ Rheumatoid Arthritis ☐ Thyroid Disease/dysfunction
☐ Crohn's Disease ☐ Parathyroid Disease ☐ Ulcerative Colitis
☐ Low Vitamin D ☐ Cushing's Syndrome
☐ Organ Transplant ☐ Anorexia Nervosa/Bulimia
☐ Breast Cancer ☐ Other Type of Cancer List:_____

Have you been treated with any of the following medications? (Please check if applicable)

Medication	Ever	Current	Medication	Ever	Current
Fosamax (Alendronate)	☐	☐	Hormone Replacement Therapy (Estrogen)	☐	☐
Actonel (Risedronate)	☐	☐	Tamoxifen (Nolvadex)	☐	☐
Boniva (Ibandronate)	☐	☐	Arimidex (Anastrozole)	☐	☐
Prolia (Denosumab)	☐	☐	Femara (Letrozole)	☐	☐
Reclast (Zoledronate)	☐	☐	Aromasin (Exemestane)	☐	☐
Forteo (Teriparatide)	☐	☐	Chemotherapy	☐	☐
Evista (Raloxifene)	☐	☐	Synthroid (Levothyroxine)	☐	☐
Miacalcin (Calcitonin)	☐	☐	Dilantin/Phenobarbital	☐	☐
Calcium/Vitamin D	☐	☐	Steroids (Prednisone) dosage _____mg	☐	☐

For Women Only…Menstrual History	YES	NO	
Are you still having menstrual periods?	☐	☐	
Have you gone through menopause?	☐	☐	age_____
Have you had a hysterectomy?	☐	☐	age_____
Have you had both of your ovaries removed?	☐	☐	☐ Right ☐ Left

For Men Only…

Have you had Prostate Cancer? ☐ Yes ☐ No If yes, Medication:_____

Completed by: _____ Date _____ Time: _____