BONE DENSITY PATIENT QUESTIONNAIRE

Ethnic Background: ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Afro-American ☐ Native American
Last menstrual period: Age Or Date:______________ Any chance you could be pregnant? ☐ No ☐ Yes
Did you have a hysterectomy? ☐ No ☐ Yes at Age:______ **If yes,** ☐ Partial or ☐ Complete
Currently on hormone replacement therapy? ☐ No ☐ Yes, how long?__________________________
If no, have you ever been on hormone replacement therapy? ☐ No ☐ Yes, how long? _______________
Any fractures since age 35? ☐ No ☐ Yes
If YES, list fractures: ____

Any metal in spine or hip? ☐ No ☐ Yes

Please check any of the below that apply to YOU:

☐ Anorexia, Bulimia	☐ Anticonvulsants	☐ Alcoholism
☐ Cancer (excluding skin cancer)	☐ Diabetes	☐ Family History
☐ Hypercalcemia	☐ Hyperparathyroid	☐ Hyperthyroid, Hypothyroid
☐ Kidney Stones	☐ Kidney Failure, Kidney Removed	☐ Lactose Intolerance
☐ Liver Disease	☐ Lupus	☐ Malabsorption/Small Bowel Disease
☐ Osteopenia	☐ Osteoporosis	☐ Paget's Disease of the Bone
☐ Prednisone, Corticosteroids	☐ Radiation/Chemotherapy	☐ Rheumatoid Arthritis

Taking any medication for the treatment of Osteopenia/Osteoporosis? If yes, please list:_________________
____
Calcium supplement? ☐ No ☐ Yes, How many milligrams?_________ How long?___________________
Do you exercise? ☐ No ☐ Yes, What Kind?__________________ How Often?___________________
In the past two weeks, have you had any exams that involved the use of dye or barium? ☐ No ☐ Yes
Are you a smoker? ☐ Never ☐ Ex-Smoker ☐ Yes How long did/have you smoked?_________
Have you had any unexpected weight loss or gain of 10 lbs. or more in the last month? _____ No _____ Yes
If YES, have you followed up with your primary care physician? _____ No _____ Yes

Patient Signature:_____________________________________Date/Time:__________________________

Referring Physician: ____

BELOW THIS LINE FOR STAFF USE ONLY

Technologist
Signature: ____Date/Time: _______________________

Visit #	
Height	
Height Loss	
Weight	

OFFICE USE ONLY
CENTER FOR WOMEN'S HEALTH
BONE DENSITY QUESTIONNAIRE

BOX:
A B C

7607 Medical Imaging

7607-0001
(02/2010)