BONE DENSITY QUESTIONNAIRE

NAME: _____ **Age:** _____

DATE OF BIRTH: _____ **MENOPAUSAL AGE:** _____ **MALE / FEMALE**

RACE: CAUCASIAN / ASIAN / AFRICAN AMERICAN / HISPANIC

ORDERING PHYSICIAN: _____

INDICATION FOR STUDY: _____

Have you ever had a bone density study before? **YES** _____ **NO**_____

When? _____ **Where?** _____

Have you ever had a previous hip or spine fracture? **YES** _____ **NO** _____

Have you had any fractures during your adult life which did not result from significant trauma(e.g. car accident)? **YES** _____ **NO** _____

Did either of your parents have a hip fracture? **YES** _____ **NO** _____

Do you smoke? **YES** _____ **NO** _____

Are you currently taking Steroids/Prednisone? **YES** _____ **NO** _____

Currently _____ **For how long?** _____ **What is your dosage?** _____ **Yes, previously**_____

Do you drink 3 or more alcoholic drinks per day? **YES**_____ **NO**_____

Are you being treated for Osteoporosis? **YES**_____ **NO** _____

Does a parent or sibling have Osteoporosis?

YES_____ **NO** _____

ARE YOU CURRENTLY OR HAVE YOU EVER TAKEN ANY OF THE FOLLOWING MEDICATIONS?

MEDICATION	PAST	CURRENTLY	FOR HOW LONG
Actonel / Atelvia (risedronate)			
Miacalcin (calcitonin)			
Forteo/ Tymlos (parathyroid hormone)			
Evista (raloxifene)			
Fosamax (alendronate)			
Reclast (zoledronate)			
HRT (estrogen / hormone therapy)			
Boniva (ibandronate)			
Prolia (denosumab)			
Aredia (pamidronate)			
Testosterone (Lupron)			
Vitamin D			
Calcium			
Acid Reflux Medications			

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Anorexia or Bulimia	**Asthma or emphysema**	**End stage renal disease**
Hyperparathyroidism	**Seizure disorders**	**Inflammatory bowel disease**
Cancer	**Type I diabetes**	**Rheumatoid Arthritis**

What was your maximum height? _____

Do you perform exercise regularly? **YES** _____ **NO** _____

Do you regularly consume dairy products? **YES** _____ **NO** _____

Do you drink caffeinated beverages? **YES**_____ **NO** _____

Do you have frequent falls or loss of balance? **YES** _____ **NO** _____

Have you ever had kidney stones? **YES** _____ **NO** _____

Have you ever had weight loss surgery? **YES** _____ **NO**_____

Have you ever had surgery of the spine, hips, legs or arms? **YES** _____ **NO** _____

Do you have any swallowing problems or suffer from heartburn? **YES**_____ **NO** _____

Have you ever been told you have arthritis of the spine? **YES** _____ **NO** _____

Have you ever been told you have scoliosis of the spine? **YES** _____ **NO** _____

Have you had any major dental issues? **YES** _____ **NO** _____

IF FEMALE:

Are you pregnant? **YES** _____ **NO** _____

Are you premenopausal? **YES** _____ **NO** _____

At what age did your periods start? _____

How many full term pregnancies have you had? _____

Have you ever missed your period for more than 6 months in a row? **YES** _____ **NO** _____
Not including pregnancy or menopause.

Have you had a hysterectomy? **YES** _____ **NO** _____

Was it a partial _____ **or total** _____**?** **At what age?** _____