

BONE DENSITOMETRY PATIENT QUESTIONNAIRE

Patient Name: _____ Date: _____ Date of Birth: _____ Age: _____

1. What is your current **WEIGHT**? _____ Pounds What is your current **HEIGHT**? _____ Feet _____ Inches
2. Have you lost any **HEIGHT**? Yes No If yes, how many inches: _____
3. Do you currently take any osteoporotic medication? Yes No
If yes, what is the name of the medication(s)? _____ How long have you been taking them? _____
If no, have you ever? Yes No
4. Do you take calcium supplements? Yes No If yes, how long? _____
5. Do you take hormone replacement? Yes No If yes, how long? _____
6. Any family history of osteoporosis? Yes No If yes, who? _____
7. Any previous: Compression spine fractures? Yes No
Hip fractures (other than from a fall)? Yes No Which hip? _____
Wrist fractures? Yes No Which arm? _____
8. Did your mother or father ever have a hip fracture? Yes No
9. Are you currently smoking cigarettes? Yes No
10. Do you take oral steroids (Glucocorticoids) or have you taken oral steroids longer than 3 months? Yes No
If yes, how long have you taken them? _____
11. Do you have a confirmed diagnosis of Rheumatoid Arthritis? Yes No
12. Do you have one of the following disorders strongly associated with secondary osteoporosis? Type 1 Diabetes, Osteogenesis Imperfecta, Untreated Hyperthyroidism, Hypogonadism, Premature Menopause (<45), Chronic Malnutrition, or Malabsorption and Chronic Liver Disease? Yes No
13. Do you drink 3 or more glasses of alcohol a day? Yes No
14. Have you had surgery to your lower back? Yes No If yes, what level? _____

Patient's Signature: _____ **Date:** _____

DO NOT WRITE BELOW THIS LINE

Age: _____ Male Female **PEDS** **Baseline** **Comparison** MRN # _____
 Fosamax Actonel Miacalcin Evista Forteo Boniva Vidura Other _____ None
Post Menopausal ___ Y ___ N **Hyperparathyroidism** ___ Y ___ N **Hyperthyroidism** ___ Y ___ N

COMMENTS: _____

C B H A Scanned by: _____ Analyzed by: _____