

MALE BONE DENSITOMETRY PATIENT QUESTIONNAIRE

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

Current **WEIGHT**? _____ pounds Current **HEIGHT**? _____ feet _____ inches

Your height at 20 years of age? _____

- Yes No Any previous fractures to your spine, hip, or forearm?
If YES, which area(s), Spine Hip (Right or Left) Forearm (Right or Left)
- Yes No Did your mother or father ever have a hip fracture?
- Yes No Do you now or have you ever smoked?
If **YES**, how many years did you smoke? _____ years
How many packs per day did you smoke? _____ packs per day
How long ago did you quit? If still smoking, mark as "0": _____ years ago
- Yes No Do you take oral steroids (Glucocorticoids) or have you taken oral steroids longer than 3 months?
If yes, how long have you taken them? _____ What is the name of the steroid you are taking? _____
- Yes No Do you have a confirmed diagnosis of Rheumatoid Arthritis?

Do you have one of the following disorders strongly associated with secondary Osteoporosis? (Please circle)

Type 1 Diabetes, Osteogenesis Imperfecta, Untreated Hyperthyroidism, Hypogonadism, Chronic Malnutrition, Malabsorption, Chronic Liver Disease

- Yes No Do you drink 3 or more glasses of alcohol a day?
- Yes No Have you had surgery to your lower back? If yes, what level? _____
- Yes No Have you ever been diagnosed with Osteoporosis?
If yes, what area, Spine Hip (Right or Left) Forearm (Right or Left)
- Yes No Do you currently take any osteoporotic medication?
If yes, what is the name of the medication? _____ How long have you been taking them? _____
Have you ever taken medications for osteoporosis, when? _____
- Yes No Do you take calcium supplements? If yes, how long? _____
- Yes No Do you have or have you ever had any of the following medical conditions? (Please circle)
Anorexia/Bulimia Any Seizure Disorders Asthma or Emphysema
Cancer, Type _____ when was it diagnosed _____ Inflammatory bowel disease
Other-Please specify: _____

Patient signature: _____ Date: _____

Technologist notes: _____

Patient MRN: _____