BONE DENSITOMETRY PATIENT QUESTIONNAIRE

Patient Name:_____ Date: _____Date of Birth: _____Age: _____

1. What is your current **WEIGHT?** _____Pounds
2. Have you gone through menopause? ☐ Yes ☐ No If Yes, at what age? _____
3. Are you premenopausal? ☐ Yes ☐ No
4. Have you had surgery to your lower back? ☐ Yes ☐ No If yes, what level? _____
5. What was your height at 20 years of age? _____
6. What is your current **HEIGHT?** _____Feet __ Inches
7. Any previous: Compression spine fractures? ☐ Yes ☐ No
   Hip fractures (other than from a fall)? ☐ Yes ☐ No Which hip? _____
8. Have you had any pathological fractures during your adult life which did not result from significant trauma (i.e. auto accident?) ☐ Yes ☐ No
   If YES, what area, ☐ Spine, ☐ Hip (Right or Left,) ☐ Forearm (Right or Left), ☐ other: _____
9. Did your mother or father ever have a hip fracture? ☐ Yes ☐ No
10. Are you currently smoking cigarettes? ☐ Yes ☐ No
11. 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?_____What is the name of the steroid you are taking? _____
12. Do you have a confirmed diagnosis of Rheumatoid Arthritis? ☐ Yes ☐ No
13. Have you ever been diagnosed with Osteoporosis? ☐ Yes ☐ No
    If yes, what area, ☐ Spine ☐ Hip (Right or Left) ☐ Forearm (Right or Left)
14. 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
15. 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 when? _____
16. Do you take calcium supplements? ☐ Yes ☐ No If yes, how long? _____
17. Do you take vitamin D? ☐ Yes ☐ No If yes, how long? _____
18. Do you have Hyperparathyroidism? ☐ Yes ☐ No
19. Do you drink 3 or more glasses of alcohol a day? ☐ Yes ☐ No
20. Do you take hormone replacement ("oral estrogen""?) ☐ Yes ☐ No If yes, how long? _____

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