

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? _____

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: _____