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, Premature Menopause (<45), Chronic Malnutrition, Malabsorption, Chronic Liver Disease

☐ Yes No ☐ Do you drink 3 or more glasses of alcohol a day?

☐ Yes No ☐ Have you gone through menopause? i**f you answered "yes", at what age?** _____

If "no" are you (circle one) Premenopausal Perimenopausal

☐ 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 take hormone replacement ("oral estrogen""?) 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 Hysterectomy
Cancer, Type _____when was it diagnosed _____ Inflammatory bowel disease
Other-Please specify: _____

Patient signature: _____ Date: _____

Technologist notes: _____
_____
_____
_____

Patient MRN:_____