

Bone Density Study Questionnaire

Name: _____ Date: _____

DOB: _____ Age: _____ Male / Female

Race: Caucasian / Asian / African American / Hispanic / Other

Height: _____ Weight: _____

Ordering Physician: _____

Have you ever had a bone density study before? **Y or N**

If yes, where and when? _____

Have you ever broken a bone? **Y or N**

If yes, state the age that the fracture occurred and describe the circumstance:

Has a parent or sibling broken a hip? **Y or N**

Does a parent or sibling have Osteoporosis? **Y or N**

What was your tallest height? (Late teens or young adult): _____

Do you have frequent falls or loss of balance? **Y or N**

If yes, how many times have you fallen in the last year? _____

Have you ever had surgery of the spine, hips, legs, or arms? **Y or N**

If yes, describe the type of surgery you had and the side affected:

Have you ever been told you have arthritis of the spine? **Y or N**

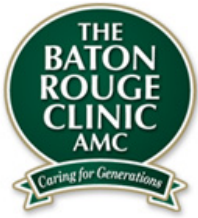
Have you ever been told you have scoliosis? **Y or N**

Are you currently receiving or have you previously received prednisone pills (cortisone)?

Yes, currently _____ **Yes, Previously** _____ **No** _____

If yes, for how long? _____

What is your dosage? _____ mg / day



Have you ever had any major dental issues? **Y or N** - If yes, describe:

Have you had a previous weight loss surgery? **Y or N** - If yes, when? _____

Do you have any swallowing problems or suffer from heartburn symptoms? **Y or N**

List any medications that you are currently taking:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List any chronic medical conditions you have:

_____	_____
_____	_____
_____	_____
_____	_____

Do you take calcium supplements? **Y or N** - If yes, _____ mg / day

Do you take Vitamin D supplement? **Y or N** – If yes, _____ units / day

Do you take a multi-vitamin daily? **Y or N**

Do you eat dairy products? **Y or N**

Do you smoke? **Y or N** – If yes, how often? _____

Do you drink alcohol? **Y or N** – If yes, how often? _____

Have you ever had kidney stones? **Y or N**



Are you currently receiving or have you previously received any of the following:

- Medications for seizures or epilepsy **Y or N**
If yes, what and for how long? _____
- Chemotherapy for cancer **Y or N**
If yes, what and for how long? _____
- Medications for prostate cancer **Y or N**
If yes, what and for how long? _____
- Medication to prevent organ transplant rejection **Y or N**
If yes, what and for how long? _____

Have you ever been treated with any of the following medications?

Medication	Ever?	Currently?	If current, how long?
Hormone Replacement Therapy			
Tamoxifen			
Raloxifene (Evista)			
Testosterone			
Etidronate (Didronel)			
Alendronate (Fosamax)			
Risedronate (Actonel)			
Intravenous Pamidronate (Aredia)			
Ibandronate (Boniva)			
Calcitonin (Miacalcin Nasal Spray)			
PTH (Forteo)			
Zoledronic Acid (Zometa)			

For women only:

Could you possibly be pregnant? **Y or N**

Are you still having menstrual periods? **Y or N**

Have you had your menopause? **Y or N** - If yes, at what age? _____

Have you had a hysterectomy? **Y or N** - If yes, at what age? _____

Have you had both of your ovaries removed? **Y or N** - If yes, at what age? _____

Before menopause, have you ever missed your periods for 6 months or more, besides during pregnancy? **Y or N**