BONE DENSITOMETRY PATIENT QUESTIONNAIRE

NAME:____ DOB:__________

Have you had a bone density test done previously? **Yes / No**

Have you been diagnosed with low bone density? **Yes / No**
(osteopenia or osteoporosis)

Do any of your family members have osteoporosis? **Yes / No**

Have you had any broken bones after the age of 20? **Yes / No**
If yes, please list:_________________________

Do you have back pain? **Yes / No**
If yes, Intermittent or Constant

Do you smoke or have a history of smoking? **Yes / No**

Do you drink more than three caffeinated beverages a day? **Yes / No**

Do you have recurrent falls? **Yes / No**

Have you ever had surgery on your LOWER BACK or HIPS? **Yes / No**
Is there hardware present?
Lower Back: **Yes / No**
Hip: Left / Right **Yes / No**

Do you have a history of any of the following conditions? (Please circle all that apply)

Diabetes	Lupus	Kidney Disease	High Blood Pressure
Seizures	Asthma	Cancer (any type)	Thyroid Problems

Do you take any of the following medications? (Please circle all that apply)

Fosomax	Actonel	Boniva	Miacalcin
Synthroid	Prednisone	Cortisone	Hormone Replacements
Multivitamin	Calcium	VitaminD	Forteo

For Women Only

Do you still menstruate? **Yes / No**
If yes, date of last cycle:_____________
If no, age at menopause: _____________

Have you taken the birth control shot Depo Provera? **Yes / No**

Have you had a hysterectomy? **Yes / No**
If yes, Partial or Complete