
**BONE DENSITOMETRY QUESTIONNAIRE**

Baseline outside comparison available not available

**Ethnicity** Black Hispanic White Asian

Name: _____

DOB: _____

no yes 1. Have you had bone density examination before?
If so where and when?

no yes 2.Have you had any examination within the past 7 days where you injected or ingested a contrast material?
i.e. Barium contrast Study, Cat Scan, MRI

no yes 3.Have you had a previous hip or vertebral fracture?

no yes **4.Have you ever had a fracture after age 40?**
What bone was broken?

no yes 5.Did either of your parents ever have a hip fracture?

no yes 6. Do you smoke?

no yes 7.Have you ever taken Glucocorticoids or prednisolone of 5mg daily?

no yes 8.Do you have a confirmed diagnosis of Rheumatoid Arthritis by a physician?

no yes 9.Do you have one of the following disorders associated with secondary osteoporosis?

Type 1 diabetes hypogonadism
osteogenesis imperfecta premature menopayse (<45)
untreated hyperthyroidism chronic liver disease
Chronic malnutrition or malabsorption

no yes 10. Do you drink 3 or more glasses of alcohol a day?

no yes 11. Do you perform weight bearing exercise regularly?

no yes 12. Do you regularly consume dairy products?

no yes 13. Do you drink caffeinated beverates?

no yes **14. Are you being treated for osteoporosis?**

**IF FEMALE:**

no yes 15. Is there any chance you might be pregnant?
date of your last menstrual period? _____

no yes 16. Have you started menopause?
If yes, at what age? _____

no yes 17. Have you had previous HYSTERECTOMY?
If yes, at what age? _____

PLEASE PLACE A CHECK MARK TO ANY THAT APPLIES TO YOU

_____ I have a history of osteoporosis
_____ I have a history of osteopenia
_____ bone pain
_____ cancer
_____ other please specify:
_____
_____

HAVE YOU EVER OR ARE YOU CURRENTLY TAKING THE FOLLOWING MEDICATION?
please place a check mark

| CURRENTLY taking | | taken in the PAST |
|---|---|---|
| _____ | Actonel (risidronate) | _____ |
| _____ | Boniva (ibandronate) | _____ |
| _____ | Evista (raloxifene) | _____ |
| _____ | Forteo (parathyroid hormone) | _____ |
| _____ | Fosamax (alendronate) | _____ |
| _____ | Estrogen/Hormone therapy | _____ |
| _____ | Miacalcin (calcitonin) | _____ |
| _____ | Reclast (zoledronate) | _____ |
| _____ | Prolia (denosumab) | _____ |
| _____ | Vitamin D | _____ |
| _____ | Calcium | _____ |

other please specify:
_____

Height ____inches Weight____lbs

_____
Patient Signature:

_____
Technologist Signature: