



BONE DENSITOMETRY QUESTIONNAIRE

Name: _____

Today's Date: _____

Patient ID: _____

Sex: F M Date of Birth: _____

Current Height: (in) _____

Weight: (lbs) _____

Referring Physician: _____

Ethnicity: _____

Menopause Age: _____

- 1. Have you had a previous hip or vertebral fracture? Yes No
- 2. Have you had any fractures during your adult life which did not result from significant trauma (e.g., auto accident)? Yes No
- 3. Did either of your parents ever have a hip fracture? Yes No
- 4. Do you smoke? Yes No
- 5. Have you ever taken Glucocorticoids? Yes No
- 6. Do you have rheumatoid arthritis? Yes No
- 7. Do you have secondary osteoporosis? Yes No
- 8. Do you drink 3 or more alcoholic drinks per day? Yes No
- 9. Are you being treated for osteoporosis? Yes No

10. Have you ever taken any of the following medications:

- Actonel (i.e. risedronate) Boniva (i.e. ibandronate)
- Evista (i.e. raloxifene) Forteo (i.e. parathyroid hormone)
- Fosamax (i.e. alendronate) HRT (i.e. estrogen/hormone therapy)
- Miacalcin (i.e. calcitonin) Protelos (i.e. strontium ranelate)
- Reclast (i.e. zoledronate) Prolia (i.e. denosumab)
- Vitamin D Calcium
- Other- Please specify _____

11. Do you have any of the following medical conditions:

- Anorexia or Bulimia Any Seizure Disorders
- Asthma or Emphysema Cancer
- End stage renal disease Inflammatory bowel diseases
- Hyperparathyroidism Hysterectomy
- Other- Please specify _____

12. What was your maximum height (inches)? _____

- 13. Do you perform weight bearing exercise regularly? Yes No
- 14. Do you regularly consume dairy products? Yes No
- 15. Do you drink caffeinated beverages? Yes No

If female:

16. At what age did your period start? _____

17. Are you premenopausal? Yes No

18. How many full term pregnancies have you had? _____

19. Have you ever missed your period for more than 6 months in a row (not including pregnancy or menopause)? Yes No