



**BONE DENSITY QUESTIONNAIRE**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please answer the following questions. If you are unsure how to answer a question, please leave the space blank and a staff member will assist you. Answers are confidential medical record information and are important to assist in the correct interpretation of your bone density examination.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referring Physician: \_\_\_\_\_ Sex: Female \_\_\_\_\_ Male \_\_\_\_\_

Race: (Please circle one that applies) African-American – Asian – Caucasian (White) – Hispanic – Other

- \_\_\_ Yes \_\_\_ No... Is there a chance that you are pregnant?
  - \_\_\_ Yes \_\_\_ No... Have you had a barium X-ray in the last 2 weeks?
  - \_\_\_ Yes \_\_\_ No... Have you had a nuclear medicine scan or injection of an X-ray dye in the last week?
  - \_\_\_ Yes \_\_\_ No... Did you take any calcium supplements today?
- (If you answered yes to any of the above, speak to the Technologist.)*

**GYNECOLOGICAL HISTORY**

- \_\_\_ Yes \_\_\_ No... Are you postmenopausal?
- \_\_\_ Yes \_\_\_ No... Did your menopause occur before the age of 45?
- \_\_\_ Yes \_\_\_ No... Have you had a hysterectomy? If so, when? \_\_\_\_\_
- \_\_\_ Yes \_\_\_ No... Have you had your ovaries removed? If so, when? \_\_\_\_\_
- \_\_\_ Yes \_\_\_ No... Do you take hormone therapy in any form at this time? If, so, what type? (Circle one that applies)  
**Premarin – Estrogen – Birth Control**
- \_\_\_ Yes \_\_\_ No... Are you currently taking any type of contraception by shot (such as Depo-Provera) that is intended to stop your periods?

**MEDICAL HISTORY**

- \_\_\_ Yes \_\_\_ No... Have you ever had a Bone Density (DEXA) Scan before?  
If so, when? \_\_\_\_\_ Where? \_\_\_\_\_
- \_\_\_ Yes \_\_\_ No... Have you taken **Cortisone** or **Prednisone** orally for over 3 months? (Circle all that apply)
- \_\_\_ Yes \_\_\_ No... Do you take thyroid medicine? If so, which do you have (Circle one that applies)  
**Hypothyroidism – Hyperthyroidism**
- \_\_\_ Yes \_\_\_ No... Do you take calcium (including TUMS), multivitamins and/or Vitamin D? (Circle all that apply)  
If so, how long? \_\_\_\_\_ How much (Dosage)? \_\_\_\_\_
- \_\_\_ Yes \_\_\_ No... Do you take any of the following medicine for osteoporosis? (Circle one that applies)  
**Actonel – Boniva – Evista – Fosomax – Miacalcin Nasal Spray**  
If so, how long? \_\_\_\_\_ How much (Dosage)? \_\_\_\_\_
- \_\_\_ Yes \_\_\_ No... Do you have family history of osteoporosis?
- \_\_\_ Yes \_\_\_ No... Has either parent had a hip fracture?
- \_\_\_ Yes \_\_\_ No... Have you had a confirmed diagnosis of Rheumatoid Arthritis?
- \_\_\_ Yes \_\_\_ No... Have you ever fractured any bones after the age of 40 (excluding hands, feet, and skull)?  
If so, which Bones? \_\_\_\_\_ How? \_\_\_\_\_

**LIFESTYLE**

- \_\_\_ Yes \_\_\_ No... Do you currently smoke?
- \_\_\_ Yes \_\_\_ No... Do you drink 3 or more alcoholic beverages daily?
- \_\_\_ Yes \_\_\_ No... Do you exercise regularly? (Walking, Running, Weight Lifting, or Weight Bearing)