BONE DENSITY QUESTIONNAIRE

Name:__________________________ Today's date________________

Account No:___________ Date of birth________________

Ethnicity: Asian/Black/Hispanic/White Gender: M or F

Height: _________ Weight: _______ Referring Doctor: ____________

Is there any chance you could be pregnant? Y or N

Have you had a hip replacement surgery? Y or N
Which hip? Left or Right

Have you had back surgery? Y or N

Do you have a family history of osteoporosis? Y or N

Have you had any previous fractures? Y or N

Has your mother or father had previous fractured hip? Y or N

Have you had a confirmed diagnoses of Rheumatoid Arthritis Y or N

Have you had long term use of glucocorticoids, ie Prednisone Y or N

Have you had a hysterectomy? Partial or Complete Y or N

Have you gone through menopause? What Age? ______ Y or N
Are you on hormone replacement therapy: Y or N

Do you take medication for bone loss? If so, which one: ________________
How long have you been on the medication? ________________

Do you take calcium? Y or N What dosage: __________
Do you take vitamin D? Y or N What dosage:__________
Do you exercise regularly? Y or N How often: ___________
Do you drink alcohol? Y or N How much: ___________
Do you smoke? Y or N How much: ___________