BONE DENSITOMETRY QUESTIONNAIRE

Name: _____ DOB: _____ Age_____

Referring Physician: _____ Height: _____ Weight: _____

Ethnicity: Caucasian _____ Black _____ Asian _____ Hispanic _____ Other _____

Do you take calcium supplements? ◯ Yes ◯ No Vitamin D supplements? ◯ Yes ◯ No

Have you ever taken medication for Osteoporosis? ◯ Yes ◯ No when? _____

Which? _____ How long? _____

Are you on steroids/glucocorticoids? ◯ Yes ◯ No which?_____ how long?_____

Do you have a Thyroid or Parathyroid condition? ◯ Yes ◯ No medication? _____

Menopause? ◯ Yes ◯ No What Age? _____ Hysterectomy? ◯ Yes ◯ No

Partial____ Complete ____

Are you on Hormone replacement therapy? ◯ Yes ◯ No how long?_____

List any other medications? _____

_____

Family history of osteoporosis? ◯ Yes ◯ No If yes, whom? _____

Parent with a hip fracture? ◯ Yes ◯ No Smoker? ◯ Yes ◯ No Dairy allergy? ◯ Yes ◯ No

Do you have an eating disorder? ◯ Yes ◯ No Rheumatoid Arthritis? ◯ Yes ◯ No

Other Diseases:_____

Have you had any surgery of the spine or hips? ◯ Yes ◯ No describe_____

Adult Fractures? _____ Due to trauma?_____

Previous bone density scans? _____ Where: _____ When_____

Reason for today's test? _____

Patient Signature_____ **Date**_____

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BMI: _____ **Technologist** _____

The ten year probability of fracture (%)

Without BMD **Major osteoporotic** _____ **Hip fracture**_____