GUILFORD RADIOLOGY
1591 Boston Post Rd., Guilford, CT 06437

Bone Density Questionnaire

If you are *scheduled to have a Bone Density Scan performed, it will be helpful for you to print this form, complete it and bring it with you to your exam appointment. You should sign it after you have reviewed it with the Technologist and have had an opportunity to ask questions.*

Patient Name: _____ Date of Birth: _____

Race/Ethnicity: _____ Weight: _____ Height: _____

Have you had this examination before? ☐ Yes ☐ No If yes, where? _____

Medications:

Do you now or have you taken any of these medications for an extended period of time?

- ☐ Fosamax
- ☐ Other Bone Strengthening Medications
- ☐ Thyroid Medication
- ☐ Steroids
- ☐ Calcium/Calcitonin
- ☐ Chemo Therapy

Conditions: Please check any that apply:

- ☐ Diabetes
- ☐ Intestinal Disease (Crohn's)
- ☐ Asthma
- ☐ Osteoporosis
- ☐ Family history of Osteoporosis
- ☐ Eating Disorders
- ☐ Hip Surgery (please indicate which side): ☐ Left ☐ Right
- ☐ Hyperparathyroidism
- ☐ Osteoarthritis
- ☐ Perceived height loss
- ☐ Lower back surgery

Life Style:

1. Do you, or have you ever smoked? ☐ Yes ☐ No If yes, what age range? _____
2. Do you exercise at least three times per week? ☐ Yes ☐ No
3. Do you consume more than three alcoholic drinks per day? ☐ Yes ☐ No
4. Do you drink coffee, tea or carbonated beverages? ☐ Yes ☐ No

---

Women Only:

1. Are you post-menopausal? ☐ Yes ☐ No If yes, at what age? _____
2. Have you had a hysterectomy? ☐ Yes ☐ No yes, at what age? _____
3. Have you ever taken hormones? ☐ Yes ☐ No yes, at what age? _____

Signature: _____ **Date:** _____

Guilford Radiology
1591 Boston Post Road, Guilford, Connecticut
203-453-5123