



BONE DENSITY QUESTIONNAIRE

If you are scheduled to have a Bone Density Scan performed, please print and complete this form 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?

- | | |
|---|---|
| <input type="checkbox"/> Fosamax | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Other Bone Strengthening Medications | <input type="checkbox"/> Calcium/Calcitonin |
| <input type="checkbox"/> Thyroid Medication | <input type="checkbox"/> Chemo Therapy |

Conditions: Please check any that apply:

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hip Surgery (please indicate which side): |
| <input type="checkbox"/> Intestinal Disease (Crohn's) | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hyperparathyroidism |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Family history of Osteoporosis | <input type="checkbox"/> Perceived height loss |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> 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: _____