



Bone Densitometry Patient Questionnaire

Date: ___ / ___ / ___

Patient Name (please print): _____ **Date of Birth:** ___ / ___ / ___

- Is there a chance that you are pregnant? Yes No
 Have you had a barium X-ray in the last two weeks? Yes No
 Have you had a nuclear medicine scan or injection of an X-ray dye in the last week? Yes No
 Have you had hyperparathyroidism or a high calcium level in your blood? Yes No

If you have answered yes to any of the above, speak to our receptionist right away.

- 1** Your age: _____ Sex: Male Female
2 Your ethnicity (check one): Caucasian (White) Black Aboriginal Asian Hispanic Other
 Your country of birth: _____
3 Have you ever had a bone density test? Yes No
 If **yes**, when and where? _____
4 Have you had a recent weight change? Yes No
 If **yes**, tell us about it: _____
5 Your tallest height (late teens or young adult): _____
6 Have you ever broken a bone? Yes No

Bone broken	Simple Fall?	If not simple fall, please describe circumstances	Age at time
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		

- 7** Has a parent or sibling had a broken hip from a simple fall or bump? Yes No
8 Has a parent or sibling had any other type of broken bone from a simple fall or bump? Yes No
9 How many times have you fallen in the last year? _____

10 Have you ever had surgery of the spine, hips, legs, or arms? Yes No
If **yes**, describe what type of surgery you had and which side was affected:

11 Are you currently receiving or have you previously received prednisone pills (cortisone)? Currently Previously Never
If **yes**, for how long? _____ What is your dose? _____ mg or _____ pills each day

12 List any chronic medical conditions that you have:

13 Are you currently receiving or have you previously received any of the following medications?

Medication for seizures or epilepsy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	For how long? _____
Chemotherapy for cancer:	<input type="checkbox"/> Yes <input type="checkbox"/> No	For how long? _____
Medication for prostate cancer:	<input type="checkbox"/> Yes <input type="checkbox"/> No	For how long? _____
Medication to prevent organ transplant rejection:	<input type="checkbox"/> Yes <input type="checkbox"/> No	For how long? _____

14 Have you been treated with any of the following medications?

		If currently, how long?
Hormone replacement therapy (estrogen):	<input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never	_____
Tamoxifen:	<input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never	_____
Raloxifene (Evista):	<input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never	_____
Testosterone:	<input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never	_____
Etidronate (Didronel/Didrocal):	<input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never	_____
Alendronate (Fosamax):	<input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never	_____
Risedronate (Actonel):	<input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never	_____
Intravenous pamidronate (Aredia):	<input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never	_____
Caldronate (Bonefos, Ostac):	<input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never	_____
Calcitonin (Miacalcin nasal spray):	<input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never	_____
PTH (Forteo):	<input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never	_____
Zoledronic acid (Zometa):	<input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never	_____
Sodium fluoride (Fluotic):	<input type="checkbox"/> Currently <input type="checkbox"/> Previously <input type="checkbox"/> Never	_____

15 How many servings of the following do you eat/drink per day (on average)?

Milk (full cup):	_____
Orange juice fortified with calcium (full cup):	_____
Yogurt (small container or 1/2 cup):	_____
Cheese:	_____

16 Do you take any calcium supplements (including Tums)? Yes No

17 Do you take any vitamin D supplements (including multivitamins and halibut liver oil)? Yes No

18 Do you smoke? Yes No

For women only:

19 Are you still having menstrual periods? Yes No

18 Before menopause, have you ever missed your periods for six months or more, besides during pregnancy? Yes No

21 Have you had your menopause?
If **yes**, at what age? Yes No

22 Have you had a hysterectomy?
If **yes**, at what age? Yes No

23 Have you had both of your ovaries removed?
If **yes**, at what age? Yes No

Thank you for your time! This information will help us analyze your bone density scan.