DIAGNOSTIC RADIOLOGY, ULTRASOUND AND BREAST CENTER, PC

Bone Density Questionnaire

Today's Date: _____

Name: _____ DOB: _____ Chart #: _____

Sex: (circle) M F Ethnic background: (circle) African American Caucasian Hispanic Other: (specify) _____

	YES	NO
Have you ever had a bone density test? If yes, where and when?_____	☐	☐
Have you lost height (become any shorter)?	☐	☐
Is there any chance you may be pregnant?	☐	☐
Are you postmenopausal? If yes, at what age did menopause begin? _____	☐	☐
Do you presently take hormone replacement therapy? If yes, how many years? _____	☐	☐
Have you ever had back surgery?	☐	☐
Do you have any metal in your spine or hips?	☐	☐
Have you ever had a fracture? If yes, please list what bone and age: _____	☐	☐
Do you take medication for thyroid problems? If yes, what medication do you take? _____	☐	☐
Have you used or do you currently require prescription medications? If yes, please list them with the frequency of use and years of use?	☐	☐
_____		
_____		
Do you take calcium pills?	☐	☐
Do you take Vitamin D or a multi-vitamin?	☐	☐
Has a physician ever told you that you have osteopenia or osteoporosis? If yes, do you take medicine for Osteopenia? Y or N Name: _____ If yes, do you take medicine for Osteoporosis? Y or N Name: _____	☐	☐
Do you have family history of osteoporosis? (mother, grandmother, aunt or sister)	☐	☐
Have you had renal (kidney) failure? If yes, are you on dialysis?	☐ ☐	☐ ☐
Do you have any kind of intestinal problem such as Crohn's disease or Ulcerative Colitis?	☐	☐
Do you drink alcohol? If yes, how many drinks per day? _____	☐	☐
Do you currently smoke cigarettes?	☐	☐
Have you ever smoked cigarettes?	☐	☐