Bone Mineral Density Questionnaire

Name: _____

Today's Date: _____ Date of Birth: _____ Patient Phone Number: _____

Referring Physician Name: _____ Physician Phone Number: _____

Sex: ☐ Male ☐ Female
Ethnic Origin: ☐ African-American ☐ White, Caucasian ☐ Hispanic ☐ Asian ☐ Other
Please check the appropriate answer:

	Yes	**No**
Gynecological History		
1. Have you gone through menopause?	_____	_____
2. Have you had a hysterectomy?	_____	_____
3. Have you had your ovaries removed?	_____	_____
4. Absence of menstruations (i.e. loss of period other than pregnancy or menopause)?	_____	_____
5. Do you take hormone therapy in any form at this time?	_____	_____
If so, what type? (Circle that applies.) 1. Premarin 2. Estrogen 3. Birth Control		
Medical History		
1. Have you ever had a Bone Density (DXA) scan before?	_____	_____
If so, when? _____ Where? _____		
2. Do you have a family history of Osteoporosis?	_____	_____
3. Have you taken Cortisone or Prednisone orally for over 3 months?	_____	_____
4. Do you take any medication for raising bone density?	_____	_____
☐Fosamax/Alendronate ☐Fosamax D ☐Boniva ☐Actonel ☐Evista ☐Zometa ☐Reclast		
If so, how long?_____		
5. Do you take supplemental calcium? ☐1000 mg ☐500 mg ☐None		
6. Do you take supplemental vitamin D? Yes No If so, How much? _____		
7. Have you had hip replacement surgery?	_____	_____
If so, which one? _____		
8. Have you had surgery on your lower back?	_____	_____

Other Medical conditions: (Check all that apply)
☐ Personal history of Osteoporosis ☐ Kidney disease
☐Hyperthyroid (overactive thyroid) ☐Parathyroid disorder
☐Hypothyroid (underactive thyroid) ☐Rheumatoid arthritis
☐Eating disorder (Anorexia/bulimia) ☐Asthma
☐Celiac Disease ☐Hypothalamic amenorrhea
☐Chronic steroid use, type and duration:
_____

Current Height: _____ Previous Height: _____ Current Weight: _____