



Office Use Only
MR # _____

Bone Density Questionnaire

Name: _____

Date of Birth: ____ / ____ / ____ Age _____

Height: _____ Weight: _____ Sex _____ Ethnicity: _____

◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆ **PATIENT HISTORY** ◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆

1. Have you had a prior bone density test? _____
2. Are you being treated for osteoporosis? _____
3. Are you taking any medication for osteoporosis? _____
4. Does your family have a history of osteoporosis? _____
5. Do you take calcium supplement? Yes No. If YES, did you take it TODAY? Yes No
6. Have you had metal screws, pins or prosthesis in either of your hips, or lower back? Yes No
7. Have you had any of the following conditions?

	NO	YES
A. Hyperthyroidism.....	<input type="checkbox"/>	<input type="checkbox"/>
B. Biliary Cirrhosis.....	<input type="checkbox"/>	<input type="checkbox"/>
C. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
D. Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
E. Other Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
F. Part of the Stomach removed	<input type="checkbox"/>	<input type="checkbox"/>
G. Intestinal or Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>
H. Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>

◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆ **WOMEN ONLY** ◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆

- | | NO | YES |
|---|--------------------------|--------------------------|
| 8. Have you gone through menopause? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Did your menopause occur before age 45? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had amenorrhea (missed periods)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever taken hormones (excluding birth control)? | <input type="checkbox"/> | <input type="checkbox"/> |
- If YES, for how many years? _____