Orange County Diagnostics

Bone Density Questionnaire—Please fill out COMPLETELY.

Name: _____

Date of Birth: _____ / _____ / _____ Age: _____

Height: _____ Weight: _____ Sex: _____ Ethnicity: _____

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1. Have you had a prior bone density test? _____
2. Are you taking any **medication for osteoporosis**? _____
3. Does your family have a history of osteoporosis? _____
4. Do you take **calcium supplement**? ☐Yes ☐No. If **YES**, did you take it **TODAY**? ☐Yes ☐No
5. Have you had a **fracture** from a trauma that should not have caused a fracture? _____
6. Is there a history of **hip fracture** in either your **mother or father**? _____
7. Do you have **metal screws, pins or prostheses** in either of your hips, or lower back? ☐ Yes ☐ No
8. Do you **currently smoke**? _____ How long? _____
9. Do you **drink 3 or more units or glasses of alcohol** daily? _____
10. Do you take **oral glucocorticoids** (EXAMPLE: at least 5 mg prednisolone) daily? _____

11. Have you had any of the following conditions?	NO	YES
A. Untreated Hyperthyroidism……..…	☐	☐
B. Type 1 Diabetes (insulin dependent)…….....	☐	☐
C. Osteogenesis Imperfecta (brittle bone disease)……..….….....	☐	☐
D. **Rheumatoid Arthritis (confirmed diagnosis)**……...…	☐	☐
E. Chronic Liver Disease……..	☐	☐
F. Hypogonadism (**men only**) ……..……	☐	☐
G. Intestinal or Bowel Disease (malabsorption)…….……..	☐	☐
H. Eating Disorders (malnutrition)……	☐	☐

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	NO	YES
12. Have you gone through menopause? ……..	☐	☐
13. Did your menopause occur before age 45?	☐	☐
14. Have you ever had amenorrhea (missed periods)?	☐	☐
15. Have you ever taken hormones (**excluding birth control**)? ……	☐	☐

If YES, for how many years? _____

Signature of patient/guardian: _____ Date: __________

10/20/17 da