

BONE DENSITOMETRY QUESTIONNAIRE

Name: _____ Date: _____

Race (circle one): Caucasian African-American Asian Hispanic Other: _____

DOB: _____ Age: _____ Referring Doctor: _____

Sex: F or M Height: _____ Weight: _____

Do you take prescription medication to treat or prevent osteoporosis? **Yes No**

If yes, prescription name: _____

Do you take medication for the treatment of your thyroid? **Yes No**

If yes, prescription: _____

Previous Fracture? **Yes No**

Parent with Fractured Hip? **Yes No**

Have you ever had surgery on your hips? **Yes No**

Have you ever had surgery on your spine? **Yes No**

Do you have any metal implants? **Yes No**

Current Smoker? **Yes No**

Steroid/Glucocorticoids Use? **Yes No**

Rheumatoid Arthritis? **Yes No**

Secondary Osteoporosis? * **Yes No**

Alcohol > 3 Servings Per Day? **Yes No**

Have you been through menopause? **Yes No** *If yes, age of onset: _____*

Have you had a contrast study within the past 8 days? **Yes No**

Have you fractured any bones, **without trauma**, recently? **Yes No**

Patient Signature

Date

***Secondary Osteoporosis Definition = type 1 (insulin dependent) diabetes, osteogenesis imperfecta in adults, untreated long standing hyperthyroidism, hypogonadism or premature menopause (<45 years), chronic malnutrition, or malabsorption and chronic liver disease.

<http://www.shef.ac.uk/FRAX/tool.aspx>