BONE DENSITY QUESTIONNAIRE

Name (print):_____Date: _____

Is there a chance that you are pregnant? Yes No
Have you had a barium xray in the last 2 weeks? Yes No
Have you had a nuclear medicine scan or injection of an xray dye in the last week? Yes No
Have you had hyperparathyroidism or a high calcium level in your blood? Yes No
IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE, SPEAK TO THE RECEPTIONIST IMMEDIATELY

1. Your Age: _____ Sex: Male _____ Female _____

2. Your ethnicity: Caucasian ____ Black ____ Aboriginal ____ Asian ____ Hispanic ____ Other ____

3. Have you ever had a bone density test: Yes No
If YES, when and where? _____

4. Have you had a recent weight change: Yes No
If YES, tell us about it _____

5. Your tallest height (late teens or young adult): _____

6. Have you ever broken a bone? Yes No
Simple fall? _____ Age when fall occurred _____
If not a simple fall, please describe circumstances below:

_____

_____

_____

7. Has a parent or sibling had a broken hip from a simple fall or bump? Yes No

8. Has a parent or sibling had any other type of broken bone from a simple fall or bump? Yes No

9. How many times have you fallen in the last year? _____

10. Have you ever had surgery of the spine, hips, legs or arms? Yes No
If YES, describe what type of surgery and which side was affected.

_____

_____

11. Are you currently receiving or have you previously received prednisone pills (cortisone)?
YES, currently _____ YES, previously _____ No _____
If YES, how long? _____ What dose? _____mg OR _____pills each day

12: Do you smoke? Yes No

13. Alcohol: 3 or more units per day Yes No

14: List any chronic medical conditions that you have: _____

_____

_____

15. Are you currently receiving or have you previously received any of the following medications?

			How Long?
Medication for seizures or epilepsy	**Yes**	**No**	_____
Chemotherapy for cancer	**Yes**	**No**	_____
Medication for prostate cancer	**Yes**	**No**	_____
Medication to prevent organ transplant rejection	**Yes**	**No**	_____

16. Have you been treated with any of the following medications?

	Ever?	Currently?	If current, how long?
Hormone Replace Therapy(Estrogen)	_____	_____	_____
Tamoxifen	_____	_____	_____
Raloxifene (Evista)	_____	_____	_____
Testosterone	_____	_____	_____
Etidronate (Didrone/Didrocal)	_____	_____	_____
Alendronate (Fosamax)	_____	_____	_____
Risedronate (Actonel)	_____	_____	_____
Intravenous pamidronate (Aredia)	_____	_____	_____
Clodronate (Bonefos, Ostac)	_____	_____	_____
Calcitonin (Miacalcin Nasal Spray)	_____	_____	_____
PTH (Forteo)	_____	_____	_____
Zoledronic acid (Zometa)	_____	_____	_____
Sodium fluoride (Fluotic)	_____	_____	_____

17. How many servings of the following do you eat/drink per day (on average)?

	Milk (full cup)	Orange juice fortified w/calcium (full cup)	Yogurt (small container or ½ cup)	Cheese
# of servings	_____	_____	_____	_____

18. Do you take any calcium supplements (including TUMS)? **Yes** **No**

19. Do you take any vitamin D supplements (including multivitamins & halibut liver oil)? **Yes** **No**

FOR WOMEN ONLY

20. Are you still having menstrual periods? **Yes** **No**

21. Before menopause, have you ever missed your periods for 6 months or more (besides during pregnancy)? **Yes** **No**

22. Have you had your menopause? If YES, what age? _____ **Yes** **No**

23. Have you had a hysterectomy? If YES, what age? _____ **Yes** **No**

Have you had both ovaries removed? If YES, what age? _____ **Yes** **No**