

## Bone Density Questionnaire

Please fill out prior to your DXA and bring to your appointment.

Name \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Date of Exam \_\_\_\_\_ Ordering physician: \_\_\_\_\_  
Current height: \_\_\_\_\_ Previous height: \_\_\_\_\_ Current weight: \_\_\_\_\_  
Ethnic origin (important as a risk factor): White Hispanic Black Asian Other: \_\_\_\_\_  
Have you had a previous Bone Density study? Yes No Date: \_\_\_\_\_ Place: \_\_\_\_\_  
Have you had a radiology scan with contrast injected within the last five (5) days? Yes No

### Menstrual History:

Date of Last Menstrual Period: \_\_\_\_\_ Age at Menopause: \_\_\_\_\_  
Hormone Replacement Therapy:  Never  Past -- Dates: \_\_\_\_\_  
 Current HRT Medication \_\_\_\_\_ Dose \_\_\_\_\_ How Long? \_\_\_\_\_

### Current Medications:

For Bones (circle): Fosamax Evista Boniva Actonel Other: \_\_\_\_\_ Dose: \_\_\_\_\_  
 Steroids -- type and dose: \_\_\_\_\_  
 Other Prescription Medications: \_\_\_\_\_

### Past Medical History:

Are you pregnant?	Yes	No		
Hysterectomy	Yes	No	Date:	_____
Removal of Ovaries	Yes	No	Date:	_____
Removal of Ovaries	Yes	No	Date:	_____
Breast Cancer	Yes	No	Date:	_____
Joint replacement	Yes	No	Date:	_____ Which joint(s)? _____
Bone Fracture	Yes	No	Date:	_____ Which bone(s)? _____

### Other Medical conditions: (Check all that apply)

Osteoporosis  Kidney disease  
 Hyperthyroid (overactive thyroid)  Parathyroid Disorder  
 Hypothyroid (underactive thyroid)  Rheumatoid Arthritis  
 Eating Disorder (Anorexia/Bulimia)  Asthma  
 None  Hypothalamic amenorrhea  
 Chronic Steroid use, type and duration: \_\_\_\_\_  
 Cancer, type: \_\_\_\_\_  
 Other: \_\_\_\_\_

### Risk Factors:

How much Calcium do you consume daily (dietary + supplemental)?  
1500 mg 1000 mg less than 1000 mg none  
Do you take supplemental Vitamin D or get 10 minutes of sunlight daily? Yes No  
Do you exercise regularly? Yes No  
Type of exercise: \_\_\_\_\_ Cardio: Amount/week: \_\_\_\_\_  
Weight lifting: Amount/week: \_\_\_\_\_  
Do you smoke cigarettes? Yes No Packs/day? \_\_\_\_\_  
Did you smoke in the past? Yes No How much? /How long? \_\_\_\_\_  
Do you consume alcohol? Yes No Drinks/Week: 1-5 5-20 More than 20