Women's Health associates

Bone Density Questionnaire

Name: ______________________________ Date: ____________________

Gender: M F Date of Birth: ______________

Ethnicity: Asian Black Caucasian Hispanic Other

Is there a chance that you are pregnant? Yes No

Have you had a barium X-ray in the last 2 weeks? Yes No

Have you had a nuclear medicine scan or injection of an X-ray dye in the last week? Yes No

Have you had hyperparathyroidism or a high calcium level in your blood? Yes No

If you answered yes to any of the above, speak to our receptionist right away.

1. Have you ever had a bone density test? Yes No

   If YES, when and where? ______________________________

2. Your tallest height (late teens or young adult) ________________

3. Have you fallen in the past 12 months? Yes No

   If YES, how many times? ______________________________

4. Have you ever broken a bone? Yes No

   If YES please explain below:

Bone Broken	Age at Occurrence	Please describe the circumstances of the fall

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

   If Yes, who and at what age? ______________________________

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

7. Have you ever had surgery of the spine, hips, legs, or arms? Yes No

   If YES, describe what type of surgery you had and which side was affected:

   ____

   ____

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8. Are you currently receiving or have you previously received prednisone pills (cortisone)?

Yes, Currently _____ Yes, Previously______ No _____
If Yes, for how long? ________ What is your dose? ________mg or ______pills each day

9. Do you have a known curvature (scoliosis) of the spine? Yes No

10. List any chronic medical conditions that you have (especially Gastric Reflux or History of Gastric Ulcers):

______________________________ ______________________________

______________________________ ______________________________

11. Please list your current medications:

____

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____

12. Do you take any calcium supplements (including TUMS) Yes No

13. Do you take Vitamin D supplements (including multivitamins and halibut liver oil)? Yes No

14. Do you smoke? Yes No

15. Do you drink alcohol? Yes No
If YES, how much per day? _________________

16. How many caffeinated drinks do you have per day?___________________________

For women only…….

17. Are you still having menstrual periods? Yes No

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

19. Are you post-menopausal? Yes No
If YES, what age did you stop having menstrual periods? ________________

20. Have you had a hysterectomy? Yes No
If YES, at what age? ___________

21. Have you had both ovaries removed? Yes No
If YES, at what age? ____________