

Bone Density History Questionnaire

Name: _____

Today's Date: _____

Patient ID: _____

Sex: ☐ Male ☐ Female

Height: (in) _____

Date of Birth: _____

Weight: (lb) _____

Referring Physician: _____

Menopause Age: _____

Ethnicity: ☐ White ☐ Black ☐ Asian ☐ Pediatric ☐ Hispanic

- 1) Have you had a previous hip or vertebral fracture? ☐ Yes ☐ No
- 2) Have you had any fractures during your adult life which did not result from significant trauma? (e.g.; auto accident?) ☐ Yes ☐ No
- 3) Did either of your parents ever fracture a hip? ☐ Yes ☐ No
- 4) Do you smoke? ☐ Yes ☐ No
- 5) Have you ever taken glucocorticoids? ☐ Yes ☐ No
- 6) Do you have rheumatoid arthritis? ☐ Yes ☐ No
- 7) Do you have secondary osteoporosis? ☐ Yes ☐ No
- 8) Do you drink 3 or more alcoholic drinks per day? ☐ Yes ☐ No
- 9) Are you being treated for osteoporosis? ☐ Yes ☐ No
- 10) Have you ever taken the following medications:

☐ Actonel (i.e. risedronate)

☐ Evista (i.e. raloxifene)

☐ Fosamax (i.e. alendronate)

☐ Miacalcin (i.e. calcitonin)

☐ Reclast (i.e. zoledronate)

☐ Vitamin D

☐ Other – Please specify: _____

☐ Boniva (i.e. ibandronate)

☐ Forteo (i.e. parathyroid hormone)

☐ HRT (i.e. estrogen/hormone therapy)

☐ Protelos (i.e. strontium ranelate)

☐ Prolia (i.e. denosumab)

☐ Calcium

- 11) Do you have any of the following medical conditions:

☐ Anorexia or Bulimia

☐ Asthma or Emphysema

☐ End stage renal disease

☐ Hyperparathyroidism

☐ Other – Please specify: _____

☐ Any seizure disorders

☐ Cancer

☐ Inflammatory bowel diseases

☐ Hysterectomy

- 12) What was your maximum height in inches? _____

- 13) Do you perform weight bearing exercises regularly? ☐ Yes ☐ No

- 14) Do you regularly consume dairy products? ☐ Yes ☐ No

- 15) Do you drink caffeinated beverages? ☐ Yes ☐ No

If Female:

- 16) At what age did your period start? _____

- 17) Are you premenopausal? ☐ Yes ☐ No

- 18) How many full-term pregnancies have you had? _____

- 19) Have you ever missed your period for more than 6 months in a row? (not including pregnancy or menopause) ☐ Yes ☐ No