BONE DENSITOMETRY QUESTIONNAIRE

NAME:____________________________________________ DATE OF BIRTH:________________________  SEX: □ M □ F

Have you had this test before? □ YES □ NO       If so, at this location? □ YES □ NO

If Female:
Are you premenopausal? □ YES □ NO       What age did you start your period?____________
Age of menopause: If not applicable, date of last menstrual period: _________________
How many full term pregnancies have you had? _________________
Have you ever missed your period for more than 6 months in a row? (not including pregnancy or menopause) □ YES □ NO

Are you or could you be pregnant? □ YES □ NO

Please circle the following, if applicable:

1. Have you had a previous hip or spine fracture? □ YES □ NO; did either of your parents? □ YES □ NO

2. Have you had any fractures during your adult life not due to any significant trauma? (e.g., car accident) □ YES □ NO

3. Do you currently smoke? □ YES □ NO; do you have 3 or more alcoholic drinks per day? □ YES □ NO

4. Have you ever taken Glucocorticoids for than 3 months? (e.g., Prednisone, oral steroids) □ YES □ NO

5. Do you have type1 diabetes (insulin dependent); hyperthyroidism, hypogonadism at premenopausal age < 45? □ YES □ NO

6. Are you being treated for osteoporosis? □ YES □ NO ; Check the following medications you have taken.
   □ Actonel □ Evista □ Fosamax □ Miacalcin □ Boniva □ Forteo
   □ Protelos □ Prolia □ HRT □ Vitamin D □ Calcium □ Others _________________ _________________

7. Do you have any of the following medical conditions? Check Please
   □ Anorexia or Bulimia □ Any Seizure disorders □ Liver disease
   □ Asthma or emphysema □ Cancer □ Hyperthyroidism (over active)
   □ Kidney Diseases □ Gastro-intestinal disease □ Adrenal gland (Cushing’s or Addison’s)
   □ Hyperparathyroidism □ Hysterectomy list others □ Others _________________ _________________

8. What was your maximum height? ______________

9. Do you perform weight-bearing exercises? (e.g., free weights, resistant bands). □ YES □ NO

10. Do you consume dairy and/or caffeinated products daily? □ YES □ NO

11. Have you had any radiological procedures using contrast agents (e.g. iodine, barium) within the last 7 days? □ YES □ NO

PLEASE REMOVE ANY METAL OR JEWELRY PRIOR TO BEING CALLED FOR THE EXAM