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# BONE DENSITY QUESTIONNAIRE

1: Name: _____ 2. Date: _____

3: Gender: M or F 4. DOB: _____

5: Build: Small? Medium? Large?

6: Referring Doctor: _____

7: Social Security #: _____

8: Have you had this examination before? Y or N
If so, at which medical facility? _____
What year? _____

9: Is there any change you could be pregnant? Y or N

10: Are you right or left-handed? RT or LT

11: Have you had a hip replacement? Y or N
If so, which one? RT or LT

12: Have you had surgery on your lower back? Y or N
If so which procedure(s)? Please list: _____

_____

_____

13: Do you have a known curvature (scoliosis) of the spine? Y or N

14: Have you had any examinations in the last 7 days where you were injected or ingested a contrast medium, ie. barium? Y or N.
If so, which exam? _____

15: Do you have a family history of osteoporosis? Y or N

16: Do you take any medications? Y or N
If so, please list: _____

_____

_____

17: Are you post-menopausal? Y or N - If so, what age? _____

18: Do you take calcium supplements? Y or N

19: Have you had hysterectomy? Y or N
If so, Partial or Complete? P or C
What was your age at the time of the hysterectomy?

20: Are you on hormone replacement therapy? Y or N
If so, how many years on estrogen? _____

21: Do you have a perceived height loss? Y or N

22: Do you or have you taken corticosteroids? Y or N

23: Do you exercise regularly? Y or N

24: Do you drink alcohol? Y or N

25: Do you smoke? Y or N

26: Do you drink caffeine? Y or N

Patient Signature: _____

Date: _____

Technologist Signature: _____

Date: _____