Bone Density Questionnaire

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

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

Current age: __________ Current height: __________ Previous height: __________ Current weight: __________

Ethnic origin (important as a risk factor): □ White □ Hispanic □ Black □ Asian □ Other

Menstrual History:

Date of last menstrual period: __________ Age at menopause: __________ Are you pregnant? □ Yes □ No

Hormone replacement therapy: □ Never □ Past – Dates: __________

Current Medications:

Hormones: □ Estrogen: __________________________ □ Progesterone __________________________

For Bones: □ Fosamax/Alendronate □ Fosamax D □ Boniva □ Actonel □ Evista □ Zometa □ Reclast

Dose: ___________________________________________________________________________________________

List all medications: _______________________________________________________________________________

________________________________________________________________________________________________

Do you have a family history of osteoporosis? □ Yes □ No Who? ___________________________________________

Do you have a family history of femur fracture? □ Yes □ No

Past Medical History:

Low Bone Density □ Yes □ No Breast Cancer □ Yes □ No

Bone Disease □ Yes □ No Joint Replacement □ Yes □ No

Removal of ovaries □ Yes □ No Bone fracture □ Yes □ No Which bone? __________________________

Other medical conditions (check all that apply):

□ Personal history of Osteoporosis □ Kidney disease

□ Hyperthyroid (overactive thyroid) □ Parathyroid disorder

□ Hypothyroid (underactive thyroid) □ Rheumatoid arthritis

□ Eating disorder (anorexia/bulimia) □ Asthma

□ Celiac Disease □ Hypothalamic amenorrhea

□ Chronic steroid use, type and duration: __________________________________________________________________

□ Cancer, type: __________________________________________________________________

□ Other: ______________________________________________________________________________________

Risk Factors:

How much dietary calcium do you ingest each day? □ 1500 mg □ 1000 mg □ Unknown

Do you take supplemental calcium? □ 1000 mg □ 500 mg □ None

Do you take supplemental vitamin D? □ Yes □ No How much? __________________________________________________________________

Does your exercise include 2½ hrs of cardio each week? □ Yes □ No

Do you lift weights twice weekly? □ Yes □ No

Do you currently smoke cigarettes? □ Yes □ No Packs/day? __________________________________________________________________

Did you smoke in the past? □ Yes □ No How much?/How long? __________________________________________________________________

Do you consume alcohol? □ Yes □ No

Did you fall in the past year? □ Yes □ No

Have you read about preventing falls? □ Yes □ No

More information on fall prevention can be found at:
http://www.lowmg.com/info/general_health/bone_density_information/preventing_falls.pdf