Bone Density Questionnaire

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

Name______________________________________ Date of birth: _________________________
Date of Exam________________________________ Ordering physician: ____________________
Current height: ________ Previous height: _________ Current weight: __________
Ethnic origin (important as a risk factor): White Hispanic Black Asian Other: _________
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

Menstrual History:

Date of Last Menstrual Period: ___________ Age at Menopause: __________________________
Hormone Replacement Therapy: ☐ Never ☐ Past -- Dates: ______________
☐ Current HRT Medication____________ Dose__________ How Long? ________

Current Medications:

☐ For Bones (circle): Fosamax Evista Boniva Actonel Other: ____________ Dose: _______
☐ Steroids -- type and dose: ____
☐ Other Prescription Medications: ____

Past Medical History:

Are you pregnant? Yes No
Hysterectomy Yes No Date: ___________
Removal of Ovaries Yes No Date: ___________
Removal of Ovaries Yes No Date: ___________
Breast Cancer Yes No Date: ___________
Joint replacement Yes No Date: ___________ Which joint(s)? ____________
Bone Fracture Yes No Date: ___________ Which bone(s)? ____________

Other Medical conditions: (Check all that apply)

☐ Osteoporosis
☐ Hyperthyroid (overactive thyroid)
☐ Hypothyroid (underactive thyroid)
☐ Eating Disorder (Anorexia/Bulimia)
☐ None
☐ Kidney disease
☐ Parathyroid Disorder
☐ Rheumatoid Arthritis
☐ Asthma
☐ Hypothalamic amenorrhea
☐ Chronic Steroid use, type and duration: ____
☐ Cancer, type: ____
☐ Other: ____

Risk Factors:

How much Calcium do you consume daily (dietary + supplemental)?
1500 mg 1000 mg less than 1000 mg none
Do you take supplemental Vitamin D or get 10 minutes of sunlight daily? Yes No
Do you exercise regularly? Yes No
Type of exercise: _____________________ Cardio: Amount/week: ________________
Weight lifting: Amount/week: ___________
Do you smoke cigarettes? Yes No Packs/day? _________________
Did you smoke in the past? Yes No How much? /How long? _______________
Do you consume alcohol? Yes No Drinks/Week: 1-5 5-20 More than 20