OSTEOPOROSIS CENTER OF SOUTH DENVER

BONE DENSITOMETRY PATIENT QUESTIONNAIRE

Name: _____

DOB: ____/____/_____ **Gender:** M F

Are you: Left handed? Right handed? **Tallest height ever:** _____

Race: Caucasian Hispanic African-American Asian Other

For Technician:
Reading Physician: W S R L Z

Today's Weight: _____# _____kg

Today's Height: _____in.

For women:

At what age did you begin your menstrual cycles? _____

Have you had a hysterectomy? Y N If yes, at what age? _____ If yes, were your ovaries removed? Y N

Have you gone through menopause? Y N If yes, at what age did your menstrual periods end? _____

Have you ever been on hormone replacement therapy? Y N

If yes, at approximately what age did you begin? _____

If yes, are you still taking replacement therapy? Y N

At what age did you stop hormone replacement? _____

During premenopause, did your menstrual cycles ever stop for longer than 6 months? Y N

Is there any chance you are currently pregnant? Y N

Have you ever been diagnosed with breast cancer: Y N

If yes, did you receive chemotherapy? Y N

If yes, have you ever taken Arimidex, Femara, or Aromasin? Y N

For men:

Have you been diagnosed with low testosterone levels? Y N

Have you ever been treated for prostate cancer? Y N

If yes, have you been treated with Lupron? Y N

General History:

Do you, or have you ever had, any of the following conditions?

Hyperthyroidism	Y N	Kidney stones	Y N
Hyperparathyroidism	Y N	Gastrectomy	Y N
Alcoholism	Y N	Small bowel resection	Y N
Rheumatoid arthritis	Y N	COPD/emphysema	Y N
Ulcerative colitis	Y N	Vitamin D deficiency	Y N
Crohn's disease	Y N	Seizure disorder	Y N
Anorexia/Bulemia	Y N	Intestinal bypass	Y N
Celiac Sprue	Y N	Chronic kidney disease	Y N

Does anyone in your immediate family have osteoporosis? Y N

If so, in whom? _____

General History (cont.):

Has either of your parents ever fractured a hip? Y N

Have you ever fractured any bones? Y N

If yes, what bone(s)? _____ At what age? _____

_____ At what age? _____

_____ At what age? _____

Did any fractures occur with little or no trauma? Y N

Have you ever had hip or back surgery? Y N

If so, what type of surgery? _____

Are you a: Smoker Non-smoker Past smoker

Do you drink alcohol? Y N

If yes, do average more than 2 drinks per day? Y N

Do you exercise? Y N

If yes, what type of exercise? _____

How many times per week? _____

Do take a calcium supplement? Y N If yes, what is your daily dosage? _____

How many servings of dairy products (milk, yogurt, cheese, ice cream) do you consume a day? _____

Does your calcium supplement contain vitamin D? Y N Do you take a dedicated vitamin D supplement? Y N

Have you ever been on steroids (prednisone, Medrol, cortisone)? Y N

If so, which steroid? _____ Current use? Y N Duration of use: _____

Are you currently, or have you previously, been treated with any of the following:

Dilantin or phenobarbital
Chemotherapy
Depo-Provera
Lupron
Thyroid replacement
Arimidex/Femara/Aromasin
Prolonged heparin therapy

Are you now, or have you been, on any of the following:

Medication	Current use	Past use	Adverse reaction?	Duration of use
Fosamax (alendronate)				
Actonel (risedronate)				
Boniva (ibandronate)				
Reclast (zoledronic acid)				
Forteo (teriparatide)				
Miacalcin (calcitonin)				
Evista (raloxifene)				
Prolia (denosumab)				

Referring physician(s): _____ Fax: _____