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Bone Densitometry Patient Questionnaire

Date: ___/___/______

Patient Name (please print): ______________________________ **Date of Birth:** ___/___/_____

Is there a chance that you are pregnant? ☐ Yes ☐ No
Have you had a barium X-ray in the last two weeks? ☐ Yes ☐ No
Have you had a nuclear medicine scan or injection of an X-ray dye in the last week? ☐ Yes ☐ No
Have you had hyperparathyroidism or a high calcium level in your blood? ☐ Yes ☐ No

If you have answered yes to any of the above, speak to our receptionist right away.

1 Your age: __________ Sex: ☐ Male ☐ Female

2 Your ethnicity (check one): ☐ Caucasian (White) ☐ Black ☐ Aboriginal ☐ Asian ☐ Hispanic ☐ Other
Your country of birth: ______________________

3 Have you ever had a bone density test? ☐ Yes ☐ No
If **yes**, when and where? ______________________

4 Have you had a recent weight change? ☐ Yes ☐ No
If **yes**, tell us about it: ______________________

5 Your tallest height (late teens or young adult): ____________

6 Have you ever broken a bone? ☐ Yes ☐ No

Bone broken	Simple Fall?	If not simple fall, please describe cirumstances	Age at time
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

7 Has a parent or sibling had a broken hip from a simple fall or bump? ☐ Yes ☐ No

8 Has a parent or sibling had any other type of broken bone from a simple fall or bump? ☐ Yes ☐ No

9 How many times have you fallen in the last year? __________

10 Have you ever had surgery of the spine, hips, legs, or arms? ☐ Yes ☐ No

If **yes**, describe what type of surgery you had and which side was affected:

____

____

11 Are you currently receiving or have you previously received prednisone pills (cortisone)? ☐ Currently ☐ Previously ☐ Never

If **yes**, for how long? ______________________ What is your dose? _______ mg or _______ pills each day

12 List any chronic medical conditions that you have:

____

____

____

13 Are you currently receiving or have you previously received any of the following medications?

Medication for seizures or epilepsy:	☐ Yes	☐ No	For how long? ______________
Chemotherapy for cancer:	☐ Yes	☐ No	For how long? ______________
Medication for prostate cancer:	☐ Yes	☐ No	For how long? ______________
Medication to prevent organ transplant rejection:	☐ Yes	☐ No	For how long? ______________

14 Have you been treated with any of the following medications?

				If currently, how long?
Hormone replacement therapy (estrogen):	☐ Currently	☐ Previously	☐ Never	______________________
Tamoxifen:	☐ Currently	☐ Previously	☐ Never	______________________
Raloxifene (Evista):	☐ Currently	☐ Previously	☐ Never	______________________
Testosterone:	☐ Currently	☐ Previously	☐ Never	______________________
Etidronate (Didronel/Didrocal):	☐ Currently	☐ Previously	☐ Never	______________________
Alendronate (Fosamax):	☐ Currently	☐ Previously	☐ Never	______________________
Risedronate (Actonel):	☐ Currently	☐ Previously	☐ Never	______________________
Intravenous pamidronate (Aredia):	☐ Currently	☐ Previously	☐ Never	______________________
Caldronate (Bonefos, Ostac):	☐ Currently	☐ Previously	☐ Never	______________________
Calcitonin (Miacalcin nasal spray):	☐ Currently	☐ Previously	☐ Never	______________________
PTH (Forteo):	☐ Currently	☐ Previously	☐ Never	______________________
Zoledronic acid (Zometa):	☐ Currently	☐ Previously	☐ Never	______________________
Sodium fluoride (Fluotic):	☐ Currently	☐ Previously	☐ Never	______________________

15 How many servings of the following do you eat/drink per day (on average)?

Milk (full cup):	______________________
Orange juice fortified with calcium (full cup):	______________________
Yogurt (small container or ½ cup):	______________________
Cheese:	______________________

16 Do you take any calcium supplements (including Tums)? ☐ Yes ☐ No

17	Do you take any vitamin D supplements (including multivitamins and halibut liver oil)?	☐ Yes ☐ No
18	Do you smoke?	☐ Yes ☐ No

	For women only:	
19	Are you still having menstrual periods?	☐ Yes ☐ No
18	Before menopause, have you ever missed your periods for six months or more, besides during pregnancy?	☐ Yes ☐ No
21	Have you had your menopause? If **yes**, at what age?	☐ Yes ☐ No __________
22	Have you had a hysterectomy? If **yes**, at what age?	☐ Yes ☐ No __________
23	Have you had both of your ovaries removed? If **yes**, at what age?	☐ Yes ☐ No __________

Thank you for your time! This information will help us analyze your bone density scan.