

BONE DENSITOMETRY PATIENT QUESTIONNAIRE

Patient Name: _____ Date: _____

1. What is your current **WEIGHT**? _____ pounds
2. What is your current **HEIGHT**? _____ Feet _____ Inches
3. Have you lost any **HEIGHT**? Yes No
If yes, how many **INCHES**? _____

4. Do you currently take any osteoporotic medication? Yes No
If yes, what is the name of the medication(s)? _____

How long have you taken the medications? _____

5. Do you take calcium supplements? Yes No
If yes, for how long? _____

6. Do you take hormone replacement? Yes No
If yes, for how long? _____

7. Any family history of osteoporosis? Yes No
If yes, who? _____

8. Do you smoke cigarettes? Yes No

9. Any previous: Compression spine fractures? Yes No
Hip fractures (other than from a fall)? Yes No
Wrist fractures? Yes No Which arm? _____

If yes, what? _____

10. Do you take steroids? Yes No
If yes, how long have you taken them? _____

DO NOT WRITE BELOW THIS LINE

Age: _____ Male Female **PEDS** Baseline Comparison MRN # _____
 Fosamax Actonel Miacalcin Evista Forteo Boniva Vidura Other _____ None
 Post Menopausal ___ Y ___ N Hyperparathyroidism ___ Y ___ N Hyperthyroidism ___ Y ___ N

COMMENTS: _____

Scanned by: _____ Analyzed by: _____