Questionnaire for Bone Densitometry Scans

Date _____

Name: _____ Date of Birth _____

Sex: Female Male Race:_____

Height : _____ft_____inches Weight:_____lbs

YES or NO Have you lost height over the past years? Amount: _____

YES or NO Are you being treated with prescription medication for Osteoporosis or Osteopenia?

If yes what medication? _____

YES or NO Do you take and Calcium supplements?

YES or NO Do you take Vitamin D?

YES or NO Do you take any hormone replacement therapies? What? _____

YES or NO Do you take any medications for acid reflux? What? _____

YES or NO Do you take oral Prednisone? For how long? _____

YES or NO Any surgeries to your spine or your hip? If yes describe:_____

_____

YES or NO Any fractures over the age of 40- What?_____

YES or NO Any chance of Pregnancy?

YES or NO Have you gone through menopause? If yes age: _____

YES or NO Have you had a Hysterectomy? If yes, partial or complete? _____

YES or NO Any personal history of Cancer? If yes, what type and when was diagnosis?

_____

Left or Right handed (Circle one)

Select which applies to you:

Current smoker

Former smoker, quit _____

Non smoker