Lexington • Ob Gyn

Bone Density Questionnaire

Patient Name: ______________________ DOB: ____________ Age ________

Ethnicity: ☐ Caucasian ☐ Asian ☐ African American ☐ Hispanic ☐ Native American ☐ Other ____________

Are you pregnant? ☐ Yes ☐ No If **No**, what was the first date of your last period? ____________

Have you had a bone density before? ☐ Yes ☐ No, If **Yes**, how long ago? ____________

Have you had a hysterectomy? ☐ Yes ☐ No If **Yes,** were your ovaries removed? ☐ Yes ☐ No

Have you experienced menopause? ☐ Yes ☐ No If **Yes**, at what age? ____________

Place an "X" by all that apply to you?

☐ Scoliosis (curvature of the spine)?
☐ Have any spinal implants or hip prosthesis?
☐ Had abdominal surgeries in the past?
☐ Spinal surgery or injury?
☐ Hip surgery or injury?
☐ Arthritis – what kind?

In the past seven (7) days have you had any of the following?

☐ Barium Contrast study ☐ Cat Scan (CT scan) ☐ Nuclear Medicine study

If you have ever broken any of the following bones, please place an "X" in the box.

☐ Ankle
☐ Foot
☐ Lower Leg
☐ Toes
☐ Clavicle
☐ Forearm
☐ Pelvis
☐ Wrist
☐ Elbow
☐ Hand
☐ Rib(s)
☐ Knee
☐ Femur
☐ Heel
☐ Shoulder
☐ Finger(s)
☐ Humerus
☐ Spine

Place an "X" by any of the following medications that you are currently taking:

☐ Fosamax
☐ Evista
☐ Forteo
☐ Actonel
☐ Boniva
☐ HRT (Combo)
☐ ERT (Estogen)
☐ Calcium supplements
☐ Calcitonin (Miacalcin)
☐ PTH-1-34
☐ Birth control
☐ Cortico Steriods (Prednisone, etc)
☐ Fluoride supplements
☐ Vitamin D

At what age did your period start? ____________

How many children do you have? ☐ Zero ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Other (specifiy) ________

What was your maximum height: ____________

Place an "X" by all that apply to you:

☐ Have been diagnosed with Osteopenia.
☐ Have been diagnosed with Osteoporosis.
☐ Have taken steroid therapy for 3 months or longer (cortisone, prednisone, etc).
☐ Have taken Depo-Provera Contraceptive Injection (CI) therapy for more then 2 years.
☐ Have a family history of Osteoporosis.
☐ Have a family history of fractures
☐ Have 2 or more alcoholic beverages per day.
☐ Drink caffeinated beverages.
☐ Diagnosed with amenorrhea.
☐ Taking seizure medication (anticonvulsants: example Dilantin)
☐ Chemotherapy (Past or Present).
☐ Currently smoke
☐ Past history of smoking.
☐ Have lost height.
☐ Diagnosed with Hyperparathyroid.
☐ Diagnosed with hyperthyroid.
☐ Weigh less than 127 pounds.
☐ Have a low dietary calcium intake (drink less than 32 ounces of milk per day).
☐ I am prone to recurrent falls.
☐ Have kidney problems (dysfunction, failure, on dialysis or have had a transplant).

Patient Signature: ______________________ **Date:** ____________