

**Bone Density Questionnaire**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Referring MD: \_\_\_\_\_

African-American       Asian       Caucasian       Hispanic

1. Is there any chance of pregnancy?-----Yes-----No
2. Did you take a calcium supplement today?----- Yes-----No
3. Have you had an examination within the last 7 days Barium?----- Yes-----No
4. Have you had any nuclear medicine exam within the last seven days? -----Yes-----No
5. Do you have a family history of osteoporosis? -----Yes-----No
6. Have you had a loss of height? -----Yes-----No  
If yes, which bone(s) \_\_\_\_\_
7. Have you ever broken any bones?-----Yes-----No
8. Have you had any surgery on your lower back? -----Yes-----No
9. Have you had hip surgery? -----Yes-----No  
Which one:      RIGHT HIP      LEFT HIP      BOTH  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
10. Have you ever been on long term steroid therapy?-----Yes-----No
11. Do you have a history of kidney dialysis? -----Yes-----No
12. Have you had a hysterectomy with both ovaries removed -----Yes-----No
13. Menopause before age 45?-----Yes-----No
14. Do you take hormone replacement medication? -----Yes-----No
15. Are you taking medication for osteoporosis?-----Yes-----No  
If yes, what? \_\_\_\_\_ How long? \_\_\_\_\_

Patient Signature: \_\_\_\_\_