

Bone Density Questionnaire

Name: _____ Gender: M F Date: _____

Date of Birth: _____ Ethnicity: (Circle one) Caucasian African-American Hispanic Asian Other

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Build: (Circle One) Small Medium Large Referring Doctor: _____

Social Security #: _____ Is there any possibility you may be pregnant? Y N

Have you had this examination before? Y N If yes, what facility? _____

Are you (circle one) right-handed or left-handed Have you had hip replacement surgery? Y N
If yes, which hip? Right Left Both

Have you had any surgeries on your lower back? If yes, what procedures? _____

Do you have a known curvature (scoliosis) of spine? Y N

Have you had any examinations in the past seven (7) days in which you were injected with or ingested a contrast material, i.e. barium? Y N If so, what exam? _____

Do you have a family history of osteoporosis? Y N

Do you take any medications? Y N
If yes, please list: _____

Do you take calcium supplements? Y N Do you or have you taken corticosteroids? Y N

Are you post-menopausal? Y N At what age did menopause occur? _____

Have you had a hysterectomy? Y N Are you on hormone replacement therapy? Y N
If yes, number of years on estrogen: _____

Do you have any perceived height loss? Y N

Do you exercise regularly? Y N Do you smoke? Y N

Do you drink alcohol? Y N Do you drink coffee? Y N

Patient signature: _____ Date: _____

Technologist signature: _____ Date: _____