Bone Density Screening Questionnaire

This confidential questionnaire helps us determine your risk factors for osteoporosis. Please complete the form and bring it with you to your bone density screening appointment.

Name: ____________________ DOB: ________ Age: ______ Date: ____________

Primary Care Physician: ____________________ Height: ______ Weight: ______ Gender: F M

Ethnicity: Caucasian African-American Hispanic Asian Other ____________ Acct #: ____________

Have you had a previous hip or vertebral fracture?	Yes	No	____________
Have you had any fractures during your adult life which did not result from significant trauma (e.g. auto accident)?	Yes	No	If yes, when and which body part?
Did either of your parents ever have a hip fracture?	Yes	No	
Do you currently smoke?	Yes	No	If yes, how many years?
Have you ever taken **oral** Glucocorticoids (e.g. Prednisone or Steroids) for 3 months or more?	Yes	No	If yes, How long? When?
Do you have rheumatoid arthritis?	Yes	No	
Do you have secondary osteoporosis as a result of another disease/condition?	Yes	No	If yes, what disease/condition?
Do you drink 3 or more alcoholic drinks per day?	Yes	No	
Do you perform weight bearing exercise regularly?	Yes	No	
Do you drink more than 5 caffeinated beverages/day?	Yes	No	
Have you or do you take thyroid medication?	Yes	No	If yes, how long? ____________
Do you have a family history of osteoporosis?	Yes	No	If yes, mother, sister, grandmother
Did you start menopause before age 45?	Yes	No	If yes, at what age? ____________
Have you had a hysterectomy?	Yes	No	If yes, what age? ____________ Both ovaries removed? ____________
Have you had a hip replacement?	Yes	No	If yes, Left Right Both
Have you had surgery on your lower back?	Yes	No	If yes, was any hardware put in? ____________
Have you had vascular or abdominal surgery?	Yes	No	If yes, is there any metal of mesh in the abdominal /pelvic area? ____________
Is there a history of personal cancer?	Yes	No	If yes, what type? ____________
Did you have chemotherapy?	Yes	No	
Did you have radiation?	Yes	No	

Have you had this examination before? Yes No If yes, when and where? ______________

Have you had an examination in the last 7 days where you had contrast material? Yes No
(barium study, CAT scan, nuclear medicine study)

Please circle any medications you may be on or have taken:

Medication	How long?	If you quit, how long ago?
Actonel (Risedronate)	How long? ______________	If you quit, how long ago? ______________
Fosamax (Alendronate)	How long? ______________	If you quit, how long ago? ______________
Boniva (Ibandronate)	How long? ______________	If you quit, how long ago? ______________
Reclast (Zoledronic)	How long? ______________	If you quit, how long ago? ______________
Prolia (Denosumab)	How long? ______________	If you quit, how long ago? ______________
Antacids	How long? ______________	If you quit, how long ago? ______________
HRT (Estrogen)	How long? ______________	If you quit, how long ago? ______________

Address: Northwest Therapy
12119 SE Stevens Court
Happy Valley, OR 97086
If you have questions, please call 503.353.1278.

IMPORTANT REMINDER:

DO NOT WEAR ANY CLOTHING THAT HAS A ZIPPER, BUTTONS, OR METAL.

DO NOT WEAR BRAS WITH UNDERWIRE OR METAL CLASPS (WOMEN).

ARRIVE 5-10 MINUTES EARLY.

Thank you for coming in for your osteoporosis screening!

Patient initials: __________ Date: __________ Tech initials: __________ Date: __________