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BONE DENSITY QUESTIONNAIRE

Patient Full Name:_____ DOB:_____

Last 4 of Social Security Number: _____ Weight:_____ Height:_____

Have you had a bone density test (DEXA) within the last 2 years? YES NO If so, where?_____

Have you previously been diagnosed with osteoporosis or osteopenia? YES NO

Have you had surgery on your hips or back that inserted hardware? YES NO

Are you currently on prescribed medication for osteoporosis or low bone mass? YES NO

If so, what medication?_____

Do you have a family history of osteoporosis? YES NO Have you broken a bone as an adult? YES NO

Has one of your parents broken a hip? YES NO Are you a current smoker? YES NO PAST

Do you have any Thyroid Disorders? None HypoThyroid (low) HyperThyroid (high)

Do you have a history of long term prescription steroid use or Epidural Steroid Injections? YES NO

Do you have any history of testosterone use (prescription or recreational)? YES NO

Have you ever taken any Anti-Depressants (SSRI's)? Prozac Celexa Zoloft Other_____

Have you ever taken any Antacids or PPI's? Prilosec Zantac Nexium Other_____

Do you drink more than 3 alcoholic beverages per day? YES NO

Do you have any of the following? Crohn's Disease Ulcerative Colitis Celiac Disease IBD

Gastric Bypass Diabetes Rheumatoid Arthritis NONE

For Females Only:

Do you consider yourself? Premenopausal Menopausal Postmenopausal

Were you under age 45 at the time of menopause? YES NO

Do you have a history of estrogen use? YES NO

Do you have a history of hysterectomy? YES NO Did they remove ovaries? YES NO

Do you have a history of breast cancer? YES NO

For Males Only:

Have you ever been diagnosed with low testosterone? YES NO

Do you have a history of prostate cancer? YES NO