

**Bone Density Questionnaire**

For office use only: Height \_\_\_\_\_ Weight \_\_\_\_\_

HENDERSON & WALTON WOMEN'S CENTER, P.C. Physician: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_ City/Zip \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Ethnicity: Asian-Black-Hispanic- White- Other \_\_\_\_\_

**Please circle one that applies:**

Is there a chance you are pregnant? YES / NO

Have you ever had a Bone Density (DEXA) Scan before? YES / NO

Where? \_\_\_\_\_ When? \_\_\_\_\_ Were the results? Normal—Osteopenia—Osteoporosis

**HISTORY**

Have you had a Hysterectomy? YES / NO

If yes, were both ovaries removed? YES / NO What age or what year? \_\_\_\_\_

Are you on hormone replacement therapy in any form? YES / NO How long?

Have you had Breast Cancer? YES / NO What year? \_\_\_\_\_

Have you gone through menopause? YES / NO If so, what age did you begin? \_\_\_\_\_

Have you had Cancer of the Uterus (womb)? YES / NO

Have you fractured any bones as an adult? YES / NO

Do you have a family history of osteoporosis? YES / NO

Has a Parent or Sibling broken a hip or vertebra from a simple bump or fall? YES / NO

Do you currently smoke? YES / NO Have you smoked in the past? YES / NO

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

**Circle any medications you are currently taking:**

Anticonvulsants

Tamoxifen

Vitamin D

Diuretics (Lasix, etc.)

Thyroid Medication

Calcium

Forteo

Fosamax (Alendronate)

Reclast

Fosteum

Depo-Provera

Miacalcin (Calcitonin)

Actonel (Risidronate)

Boniva

Evista (Raloxifene)

Long-term Steroids (Prednisone, Cortisone, etc.)

Other: \_\_\_\_\_

**Please circle any of the following conditions or procedures you have had:**

Hyperthyroidism (overactive thyroid gland)

Cirrhosis of the liver

Kidney disease

Blood Clots

Eating disorder (anorexia, bulimia, etc.)

Hip Replacement (LEFT, RIGHT or BOTH)

Part of stomach removed

Gastric Bypass/Lap Band

Spine Surgery (UPPER, MIDDLE, or LOWER)

Rheumatoid Arthritis