



BONE DENSITY SCAN PATIENT QUESTIONNAIRE

Name: _____ DOB: _____ Age: _____ Today's Date: _____

Female Male Current Weight _____ Current Height: _____

Race/Ethnicity: Caucasian African American Hispanic Asian Native American Other

Name of referring doctor or other healthcare provider that should receive a copy of this report:

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1. Yes No Have you had a bone density scan performed previously? If so, where? _____
 2. Yes No Do you have a family history of osteoporosis or weak bones?
 3. Yes No Have you fractured any bones in your adult life? If yes, which bones? _____
 4. Yes No Have you had a recent Myelogram, Nuclear Medicine Bone Scan, or Barium Test (in the last 2 weeks)? **If YES, please schedule your BMD exam at least 2 weeks from the date of that exam.**
 5. Yes No Do you currently smoke cigarettes?
 6. Yes No Do you take a daily calcium supplement?
 7. Yes No Have you had hip surgery?
 8. Yes No Have you had spine surgery?
 9. Yes No Have you been treated for osteoporosis or weak bones? If Yes, what kind of treatment?
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Please Mark if you are taking any of the following medications or treatment?

- | | |
|---|-------------------------|
| ____ Steroids (Prednisone, Cortisone) | ____ Thyroid Medication |
| ____ Anticonvulsants (for seizures, epilepsy) | ____ Chemotherapy |
| ____ Diuretics (Lasix, Bumex, Edecrin, "Water Pills") | ____ Heparin |
| ____ Fosamax | |

Please Mark if you are taking any of the following medications or treatment?

- | | |
|----------------------------------|---|
| ____ Hyperthyroidism | ____ Kidney Disease |
| ____ Rheumatoid Arthritis | ____ Diabetes |
| ____ Intestinal or Bowel Disease | ____ Eating Disorders (Anorexia, Bulimia) |
| ____ Hyperparathyroidism | |

Remaining Questions for Women Only

- | | | |
|-----|----|--|
| Yes | No | Is there a chance that you are pregnant? |
| Yes | No | Have you ever had any children? |
| Yes | No | Have you reached menopause?
If YES, at what age? _____ |
| Yes | No | Have you ever taken hormones (not including birth control pills)? If YES, for how long?
_____ |

Have you had any of the following conditions?

- | | | |
|-----|----|-----------------------------|
| Yes | No | Hysterectomy |
| Yes | No | Ovaries Removed |
| Yes | No | Breast Cancer |
| Yes | No | Cancer of the Uterus (womb) |

Apply Radiology Name Label Here