BONE DENSITY SCAN PATIENT QUESTIONNAIRE

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

☐ Female ☐ Male Current Weight _____ Current Height: ____' _____" Height as a young adult: ____'_____"

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:

_____

1. Yes No Have you had a bone density scan performed previously? If so, where? _____
2. Yes No Have you had a **bone density heel scan**?
3. Yes No Do you have a family history of osteoporosis or weak bones?
4. Yes No Have you fractured any bones in your adult life? If yes, which bones? _____
5. 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.**
6. Yes No Do you currently smoke cigarettes?
7. Yes No Do you take a daily calcium supplement? Yes No Does it contain Vitamin D?
8. Yes No Have you had hip surgery that includes metal being placed in your hip?
9. Yes No Have you had spine surgery that includes metal being placed in your spine?
10. Yes No Have you been treated for osteoporosis or weak bones?

If Yes, what kind of treatment?

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

_____Steroids (Prednisone, Cortisone)
_____Anticonvulsants (for seizures, epilepsy)
_____Diuretics (Lasix, Bumex, Edecrin, "Water Pills")
_____Fosamax (Alendronate)
_____Thyroid Medication
_____Chemotherapy
_____Heparin
_____Boniva

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

_____Hyperthyroidism
_____Rheumatoid Arthritis
_____Intestinal or Bowel Disease
_____Hyperparathyroidism
_____Kidney Disease
_____Diabetes
_____Eating Disorders (Anorexia, Bulimia)

<u>Remaining Questions for Women Only</u>

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

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