

# THE IMAGING CENTER OF LAS CRUCES RADIOLOGY



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## BONE DENSITY PATIENT HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Sex:       Female     Male

Current Height: (in.) Weight: (lb.) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Menopause Age: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Other - Please specify: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Previous Bone Density: Where \_\_\_\_\_ When \_\_\_\_\_

1. Have ever taken any of the following medications:

- |                                  |                                   |  |
|----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Fosamax | <input type="checkbox"/> Actonel  | <input type="checkbox"/> Cortico Steroids (Prednisone, etc.) |
| <input type="checkbox"/> Evista  | <input type="checkbox"/> Estrogen | <input type="checkbox"/> Miacalcin                           |
| <input type="checkbox"/> Forteo  | <input type="checkbox"/> Calcium  |  |

Other - Please specify: \_\_\_\_\_

2. At what age did your period start? \_\_\_\_\_

3. How many children do you have? \_\_\_\_\_

4. What was your maximum height? (inches) \_\_\_\_\_

5. Do you have a family history of osteoporosis?  Yes  No

6. Do you perform weight bearing exercises regularly?  Yes  No

7. Do you regularly consume dairy products?  Yes  No

8. Have you ever missed your period for more than 6 months  
in a row (not including pregnancy or menopause)?  Yes  No

9. Have you had any fractures during your adult life which did  
not result from significant trauma (i.e., auto accident)?  Yes  No

10. Do you smoke?  Yes  No

11. Do you drink more than 2 alcohol drinks daily?  Yes  No

12. Do you drink caffeinated beverages?  Yes  No

13. Do you have any of the following medical conditions?  Yes  No

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Hyperparathyroidism | <input type="checkbox"/> Rheumatoid Arthritis        |
| <input type="checkbox"/> Hysterectomy    | <input type="checkbox"/> Asthma or Emphysema | <input type="checkbox"/> Any Seizure disorders       |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Anorexia or Bulimia | <input type="checkbox"/> Inflammatory Bowel Diseases |