Tower Radiology Centers

BONE MINERAL DENSITY QUESTIONAIRE

PATIENT NAME: _____ DATE: _____

DOB: _____ HEIGHT: _____ WEIGHT: _____

ETHNIC BACKGROUND (Circle one) Caucasian Asian Hispanic African American Other _____

PATIENT HISTORY

When was your last DEXA (Bone Density) scan? _____ If < 1year, why? _____

Have you ever been diagnosed with Osteoporosis? Yes No
If yes, how? by x-ray by Dexa Other _____

Have you entered menopause? Yes No If yes, when? _____

Have you had a hysterectomy? Yes No If yes, when? _____

Have you had your ovaries removed? Yes No If yes, when? _____

Is there a family history of Osteoporosis? Yes No If yes, who? _____

Do you have a history of back pain? Yes No

Do you have rheumatoid arthritis? Yes No

Are you lactose intolerant? Yes No

Have you ever broken bones as an adult? Yes No Which bone? _____

Have you ever had surgery to the hip or spine? Yes No What type? _____

Do you have a history of cancer? Yes No What type? _____
When? _____

Do you have any type of thyroid disease/dysfunction? Yes No

Do you have any type of parathyroid disease/dysfunction? Yes No

CURRENT MEDICATIONS

Are you currently taking Osteoporosis Medicine? Yes No
If yes, which one (circle)? Actonel Didronel Evista
Fosamax Miacalcin Premarin Other

Are you taking any calcium supplements? Yes No How much? _____

Are you currently on Hormone Replacement Therapy (HRT)? Yes No Which one? _____

Are you currently on any steriods? Yes No Which one? _____

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