Barnabas Health Osteoporosis Center

Bone Densitometry Questionnaire

Name (print): ______________________________ Date: ______________

Is there a chance that you are pregnant? **Yes** **No**

Have you had a barium X-ray in the last 2 weeks? **Yes** **No**

Have you had a nuclear medicine scan or injection of an X-ray dye in the last week? **Yes** **No**

If you answered yes to any of the above, speak to our receptionist right away.

1. Your date of birth: ______________ Sex: Male Female
2. Your ethnicity (circle one): White Black Asian Hispanic Other: ______________
3. Have you ever had a bone density test? **Yes** **No**
   If YES, when and where? ______________________________
4. Have you ever had surgery of the spine, hips, legs or arms? **Yes** **No**
   (What surgery was done & where?) ______________________________
5. Have you had a recent weight gain or weight loss? **Yes** **No**
   If YES, how much? ______________ over what time period? ______________
6. Your tallest height (late teens or young adult): ______________
7. **If you have ever broken a bone other than fingers, toes, or face, as an adult, list it below:**

Which bone was broken?	Due to a fall from standing height?	Please describe the circumstances which led to the break or fracture.	Age when this occurred

8. **Are you taking any of the following now or in the past? (answer each question)**

Nutrition and Medication	Currently taking	Took in past	For how long?	Never
3 or more calcium-rich foods and/or drinks daily				
Calcium supplements				
Multivitamin				
Vitamin D supplement (alone or with calcium)				
Estrogen Patch or Pills only (if in past, indicate when stopped)				
Fosamax *(alendronate)*				
Actonel/Atelvia *(risedronate)*				
Boniva *(ibandronate)*				
Evista *(raloxifene)*				
Miacalcin or Fortical nasal spray *(calcitonin)*				
Testosterone				
Tamoxifen				

IV or Injectable: *Please indicate start date and last treatment date.*

Prolia start date: ______________ last treatment date: ______________

Forteo start date: ______________ last treatment date: ______________

Reclast start date: ______________ last treatment date: ______________

Boniva start date: ______________ last treatment date: ______________

Zometa start date: ______________ last treatment date: ______________

9. **Risk factors for osteoporosis. Indicate if any of the following apply to you:**

Risk Factor		**Yes**	**No**
My parent or sibling has had a hip fracture			
My parent or sibling has or had osteoporosis			
My Personal History			
Started periods or went into puberty at age 15 or later			
Eating disorder (ever)			
Emphysema or chronic bronchitis			
Crohn's disease			
Stomach resection or gastric bypass			
Celiac disease (sprue)			
Rheumatoid arthritis (*not osteo- or degenerative arthritis*)			
Depression			
Kidney stones			
Kidney failure or dialysis			
HIV infection or AIDS			
Diabetes			
I have fallen more than once in the past year			
	Now	**In past**	**Never**
Grave's disease (current hyperthyroidism)			
More than 14 drinks of alcohol per week			
Smoking			
Hyperparathyroidism			
High calcium level in blood			

**** Please Verify Medication***

10. **Are you currently taking or have you previously taken any of the following medications?**

	Currently taking	**Took in past**	**For how long?**	**Never**
Cortisone pills (prednisone, Decadron, Medrol) for more than 3 mos.				
Anti-seizure medications (such as Dilantin, Valproate, Lamictal, Tegretol, Carbamazipine, Phenobarbital, Topamax)				
Thyroid hormone (Synthroid, Levoxyl, Thyroxine)				
Breast Cancer treatment with Femara, Arimidex, Aromasin				
Treatment for prostate cancer to lower hormone levels				
Medication to prevent organ transplant rejection				
Chemotherapy for cancer				
Avandia or Actos for diabetes				
Antidepressants (Celexa, Cymbalta, Effexor, Lexapro, Luvox, Paxil, Prosac, Prestiq, Zoloft)				
Stomach acid medication (Aciphex, Nexium, Omeprazole, Prilosec, Protonix)				

Please list other medical problems and medications: ______________________________

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For women only...

- Are you still having menstrual periods? **Yes** **No**
  If yes: Are you having any symptoms of approaching menopause? Yes No
  Did you have at least 10 periods in the past year? Yes No
- Before menopause, did you ever skip your periods for 6 months or more except during pregnancy? **Yes** **No**
- Are you going through or already had your menopause? *(If yes, at what age? _____)* **Yes** **No**
- Have you had both ovaries removed? *(If yes, at what age? _____)* **Yes** **No**