



Patient label

BONE DENSITY QUESTIONNAIRE

Please complete this questionnaire while waiting for your Bone Mineral Density test.

This document will be reviewed with you. A staff member will measure your height and weight.

Name _____ Age _____ Male/Female

If you answer yes to any of the following 3 questions, please speak to the receptionist immediately:

1. Is there any chance that you are pregnant?yes / no
2. Have you had a barium enema or barium drink in the past 2 weeks?.....yes / no
3. Have you had a nuclear medicine scan or x-ray dye in the past week?"yes / no

The following information will help us to assess your future risk for fracture.

4. Have you ever had a bone density test before?yes / no

If yes, when and where? _____

5. Have you ever had surgery of the spine or hips?yes / no

6. Have you ever broken/fractured any bones after age 40?.....yes / no

7. Have you taken prednisone/cortisone for more than 3 months in the past 12 months?.....yes / no

How long have you been taking them? _____ Dose: _____

8. Are you currently being treated with medication(s) for osteoporosis?.....yes / no

If yes, which medication(s) and for how long? _____

FOR OFFICE USE ONLY - PLEASE DO NOT WRITE IN THIS SECTION

LSC- AP SPINE _____ g/cm² LSC TOTAL HIP _____ g/cm² TECH SIGNATURE _____

Patient height _____ cm. Patient weight _____ kg.

Additional History/Medications _____

Smoker _____ 3+Alcohol Daily _____ RA _____ Early Menopause _____ Family Hx Hip # _____