RIVER RANCH RADIOLOGY

BONE DENSITY PATIENT QUESTIONNAIRE

Patient Name: _____ Height: _____ Weight: _____

Social Security Number: _____ Date of Birth: _____

Physician Treating Your Symptoms: _____

Answer the following questions by checking the appropriate response (yes or no).

	Yes	No
Gynecologic History (women only)		
1. Have you had a hysterectomy? If yes, which year _____	❑	❑
2. If you had a hysterectomy, were your ovaries removed?	❑	❑
3. Have you entered menopause? If yes, which year _____	❑	❑
Medications		
1. Are you taking hormone replacement pills or using patches?	❑	❑
2. Do you take cortisone, prednisone, or other steroids for treatment of asthma, arthritis, or cancer?	❑	❑
3. Do you take calcium?	❑	❑
4. Do you take Vitamin D?	❑	❑
5. Do you take thyroid medication?	❑	❑
6. Do you take medication for osteoporosis?	❑	❑
Lifestyle		
1. Do you smoke tobacco products? If yes, how many packs per day _____	❑	❑
2. Do you drink alcoholic beverages? If yes, on average how many per day _____	❑	❑
Fractures / Falls & Surgery		
1. Have you ever broken any bones?	❑	❑
If yes, please list _____		
2. Have you had spinal surgery?	❑	❑
3. Have you had hip surgery?	❑	❑
Pregnancy		
1. Last menstrual date _____.		
2. Are you pregnant?	❑	❑
3. Estimated Date of Birth _____.		
4. Are you nursing?	❑	❑
History of Osteoporosis		
1. Does anyone in your immediate family have osteoporosis?	❑	❑
If yes, please circle the family member(s): Mother Father Sister(s) Brother(s)		
Do you have any cultural or religious practices we need to consider?	❑	❑
Have you had a contrast procedure (CT contrast, X-ray barium or iodine, MRI contrast) within the last 5 days?	❑	❑

When is your next doctor's appointment? _____

Patient Signature: _____ **Date:** _____