

## **BONE DENSITOMETRY QUESTIONNAIRE**

Name \_\_\_\_\_

Age \_\_\_\_\_ Female \_\_\_\_\_ Male \_\_\_\_\_

Age at Menopause \_\_\_\_\_

Women:	Yes	No
Have you had a hysterectomy? .....	_____	_____
Have you ever taken Estrogen? .....	Yes _____	No _____
From when _____ to when _____	Yes	No

Men and Women:		
Do you have a family history of osteoporosis? .....	_____	_____
Have you had bone fractures as an adult? .....	Yes _____	No _____
Do you have a history of arthritis? .....	Yes _____	No _____
Do you have a history of hyperthyroid? .....	Yes _____	No _____
Do you have a history of hyperparathyroidism? .....	Yes _____	No _____
Do you have a history of steroid treatment? .....	Yes _____	No _____
(Prednisone, Cortisone,)		
If yes, when and for how long? _____		

Are you taking osteoporosis medications? .....	Yes _____	No _____
Type _____ How long? _____		
Are you taking Calcium supplements? .....	Yes _____	No _____
If yes, how much per day? _____		
Are you taking Vitamin D? .....	Yes _____	No _____
If yes, how much per day? _____		

What was your most recent height? \_\_\_\_\_ weight? \_\_\_\_\_  
 Prior scan location? \_\_\_\_\_ Year \_\_\_\_\_  
 If you've had a decrease in height, how much? \_\_\_\_\_

Technologists Notes: