Radiology Imaging Center
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BONE MINERAL DENSITY QUESTIONNAIRE

Today's Date: _____

Last Name: _____ First Name: _____

Date of Birth: _____ Sex: ◯ Female ◉ Male

Ethnic Origin: ☐ African American ☐ White, Caucasian ☐ Hispanic ☐ Asian ☐ Other

Height: _____ Weight: _____

1. Have you had barium or IV contrast for any X-Ray, CT, or Nuclear Medicine exam in the past week? Y / N
2. Do you have family history of Osteoporosis? Y / N
3. Have you had previous bone density exam? Y / N
   When: _____
   Where: _____
4. Have you had any of the following back or hip conditions? Check all that apply.
   ☐ Back Surgery ☐ Left / Right Hip Surgery
   ☐ Curvature of the spine ☐ Broken Vertebrate Prosthesis
   ☐ Other, Please specify: _____
5. Have you been diagnosed with any of the following conditions? Please check all that apply.
   ☐ Hyperthyroid (overactive thyroid) ☐ Kidney disease
   ☐ Hypothyroid (underactive thyroid) ☐ Parathyroid disorder
   ☐ Eating disorder (Anorexia/bulimia) ☐ Rheumatoid arthritis
   ☐ Celiac disease ☐ Hypothalamic amenorrhea
   ☐ Chronic steroid use, type and duration: _____
6. Do you take supplemental calcium? ☐ 1000 mg ☐ 500 mg ☐ None
7. Do you take any medication for raising bone density
   ☐ Fosamax/Alendronate ☐ Fosamax D ☐ Boniva ☐ Actonel ☐ Evista
   ☐ Zometa ☐ Reclast
   If so, how long? _____

Female patients only:

1. Have you gone through menopause? Y / N
2. Have you had a hysterectomy? Y / N
3. Have you had your ovaries removed? Y / N
4. Absence of menstruations (loss of period other than pregnancy or menopause)? Y / N
5. Do you take hormone therapy? Y / N
   If so, what type? ☐ Premarin ☐ Estrogen ☐ Birth Control

Signature: _____ **Date:** _____