STAMFORD HEALTH
Healing. Reimagined.

DIAGNOSTIC IMAGING CENTER

BONE DENSITY

PATIENT HISTORY QUESTIONNAIRE

PATIENT ID STICKER

Name _____ Prior Bone Density: _____Yes_____No_____
Patient ID: _____ Referring Physician:_____
Date of Birth:_____ Ethnicity: _____
Sex: _____F _____ M

Technologist Will Measure

Current Weight: _____ Height:_____ BMI Value: _____Forearm (cm) :_____

1. Age at menopause: _____
2. Have you had a previous hip or vertebral fracture or surgery? Yes ___ No___
3. Have you fractured any bones after the age of 35? Yes ___ No___
   If so, which bones? _____
4. Did either of your parents ever have a hip fracture? Yes ___ No___
5. Do you currently smoke? Yes ___ No___
6. Do you drink 3 or more alcoholic drinks per day? Yes ___ No___
7. Have you taken an oral steroid medication for more than 3 months at a time? Yes ___ No___
8. Do you have rheumatoid arthritis? Yes ___ No___
9. Are you being treated for secondary osteoporosis? Yes ___ No___

10. Do you have any of the following medical conditions:

___ Anorexia or Bulimia
___Asthma or Emphysema
___ End stage renal disease
___ Hyperparathyroidism
___ Cushing's disease
___Malabsorption syndrome - i.e. Celiac Disease
___ Multiple Sclerosis
___ Scurvy
___ Other – Please specify: _____
___ Any seizure disorder
___ Inflammatory bowel disorder
___ Type I Diabetes (insulin Dependent)
___ Hysterectomy/ Ovaries removed
___ Liver impairment
___ Hyperthyroidism
___ COPD
___Cancer

11. Have you ever taken any of the following medication?

___ Actonel (Risedronate)
___ Evista (Raloxifene)
___ Fosamax (Alendronate)
___ Miacalcin (Calcitonin)
___ Reclast (Zoledronate)
___ Vitamin D
___ other- please specify_____
___ Boniva (Ibandronate)
___ Forteo (parathyroid hormone)
___ HRT (estrogen/hormone therapy)
___ Protelos (strontium ranelate)
___ Prolia (Denosumab)
___ Calcium

12. What was your maximum height (inches)? _____
13. Do you perform weight bearing exercises regularly? Yes ____ No_____
14. Do you regularly consume dairy products? Yes ____ No_____
15. Do you drink caffeinated beverages? Yes ____ No_____
16. Have you ever had any type of cancer, with chemotherapy or radiation treatment? Yes ____ No___
    If yes, what type? _____
    Please list treatment medications _____
17. Are you premenopausal? Yes _____ No _____
18. Amenorrhea? (Menstrual cycle stopped, not associated with menopause, pregnancy or nursing) Yes____ No ___