

ACC# \_\_\_\_\_  
(office use only)

### BONE DENSITY QUESTIONNAIRE

MR# \_\_\_\_\_  
(office use only)

1. Name: \_\_\_\_\_
2. Today's date: \_\_\_\_\_
3. Referring Doctor: \_\_\_\_\_
4. Social Security #: \_\_\_\_\_
5. Date of Birth: \_\_\_\_\_
6. Gender: (circle one) *M or F*
7. Ethnicity: Asian / Black / Hispanic / White
8. Height \_\_\_\_\_
9. Weight \_\_\_\_\_
10. Have you had a bone density test before? (circle one) *Y or N*  
If so, at which medical facility? \_\_\_\_\_
11. Are you right or left handed? (circle one) *RT or LT*
12. Have you had hip replacement surgery? (circle one) *Y or N* If so, which one? (circle one) *RT or LT*
13. Have you had surgery on your lower back? (circle one) *Y or N* If so, please list procedure(s):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
14. Do you have a family history of osteoporosis? (circle one) *Y or N*
15. Do you have a perceived height loss? (circle one) *Y or N*
16. Do you exercise regularly? (circle one) *Y or N*
17. Do you smoke? (circle one) *Y or N*
18. Do you take calcium supplements? (circle one) *Y or N*
19. Do you now or have you taken corticosteroids? (circle one) *Y or N*
20. If you are taking medications, please list here: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### FOR WOMEN

21. Are you postmenopausal? (circle one) *Y or N* - If so, at what age did you begin menopause? \_\_\_\_\_
22. Have you had a hysterectomy? (circle one) *Y or N*  
If so, were your ovaries removed? (circle one) *Y or N*  
What was your age at the time of your hysterectomy? \_\_\_\_\_
23. Are you on hormone replacement therapy? (circle one) *Y or N*  
If so, how many years on estrogen? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Technologist: \_\_\_\_\_