ACC# ____________________ (office use only)

MR# ____________________ (office use only)

BONE DENSITY QUESTIONNAIRE

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: ______________________