

Bone Density QUESTIONNAIRE

Patient Name (print): _____

Date of Birth: _____ Date: _____ X-ray No. _____

Answer the questions by checking the appropriate response (yes, no don't know) to the right. If your answer is "yes", enter additional information in box at left.	Yes	No	Don't know
Gynecologic history (women only)			
• Are (were) your periods regular between ages 18 and 40 years			
• Did you ever have intervals with few or no bleeding cycles, other than during pregnancy?			
• Age _____ Length of time _____			
• Have you had a hysterectomy? If yes which Year _____			
• If "yes" were your ovaries also removed?			
• Have you entered menopause? If yes which Year _____			
Medications			
• Are you now taking hormone replacement pills or using patches?			
• Do you take cortisone, prednisone, or other steroids for treatment of asthma, arthritis, or cancer?			
• Do you ever take sleeping pills? If yes how often _____			
Lifestyle			
• Do you take thyroid medication?			
• Do you smoke cigarettes? Packs/day _____			
• Do you drink alcoholic beverages? Drinks/day _____			
• Do you drink beverages with caffeine? (coffee, tea, cola) _____			
• Average how much a day _____			
• Do you exercise regularly? Amount/day? _____			
Fractures and falls			
• Have you ever broken any bones?			
• Year(s) _____ Site(s) _____			
• How _____			
History of osteoporosis and back pain			
• Does anyone in your immediate family have osteoporosis?			
• Circle choices Mother Father Sister(s) Brother(s)			
• Do you ever have back pain?			
• Circle choices Mild or severe, dull or sharp, intermittent or constant			

Source: Guidelines of care on Osteoporosis for the primary care physician, presented by the Foundation for Osteoporosis Research and Education, Sec. III, July 1997