Partners In Women's Health

Jeffrey M. Litt, M.D., FACOG
Marc A. Kaufman, M.D., FACOG
Anthony Shaya, M.D., FACOG
Sweta Tina Mehta, D.O.
Nancy C. Galyon, A.R.N.P.
Ann P. Casale, A.R.N.P.

BONE DENSITY QUESTIONNAIRE

Patient Name: (print) _____ Gender: F / M Height _____ Weight _____

Referring Provider: _____ DOB: _____ Actual Age: _____

African American { } Asian { } Caucasian { } Hispanic { } Native American { } Other { }_____

Have you had previous bone density studies? Y / N
If yes, when? _____ Where? _____

CIRCLE ONE: Y (yes) or N (no)

Have you had:

Height loss? Y / N
Hip replacement? Y / N If yes: Right / Left / Both (Please circle)
Back surgery? Y / N
If yes, please describe and include if any hardware placed is lumbar: _____
_____
Any fractures during your **adult** life? Y / N
If yes, please indicate site(s) of fracture and cause: _____
Due to trauma and/or motor vehicle accident? Y / N
Low dietary calcium intake (lifelong)? Y / N

If menopausal, your actual age of menopause (when you were 1 year without menstruation): _____
Have you had a prolonged (>1 year) period of time that your menstrual cycle stopped **prior** to menopause? Y / N
Do you have a parent with a history of a hip fracture? Y / N
Do you currently smoke? Y / N Have you smoked in the past? Y / N
Do you take a calcium supplement daily? Y / N
If so, how much? _____ mg/day
Calcium citrate **OR** Calcium carbonate **(CIRCLE ONE)**
Does it contain vitamin D? Y / N How much? _____i.u.
Do you divide your calcium dose daily? State how taken: _____
Do you exercise regularly? Y / N Weight bearing? Describe: _____
Do you exercise infrequently or not at all? Y / N
Do you drink more than three alcoholic beverages per day? Y / N
Do you drink more than two caffeinated beverages per day? Y / N

CONTINUED ON THE OTHER SIDE

Have you had any of the following conditions or surgeries?

- **Hyper**thyroidism or **Hyper**parathyroidism? Y / N
- Kidney disease? Y / N
- Rheumatoid Arthritis? Y / N
- Eating disorders (anorexia nervosa, bulimia, etc)? Y / N
- Ovaries removed before menopause? Y / N
  If yes: Both / Right / Left **(Please circle one)**

Are you currently taking any of the following medications or treatments?

- Steroids (prednisone, cortisone, etc.) Y / N
- Thyroid medication Y / N
- Anticonvulsants (for seizures, epilepsy, etc.) Y / N
- Hormone Replacement Therapy Y / N
- Birth Control Y / N
- Other vitamins
  - List: _____

Have you been given a previous diagnosis of osteopenia? Y / N ....osteoporosis? Y / N

*Are you **currently** on medication for the treatment of osteoporosis?* Y / N
If yes, how long have you been taking? _____

Which one? Actonel { } Boniva, oral { } Boniva, injectable { } Evista { } Forteo { }
Fosamax { } Prolia { } Reclast { } Other { } _____

Have you had any studies using IV contrast dye within the past 72 hours? Y / N

Do you have an umbilical body piercing? Y / N
If yes, is it removable? Y / N (This will interfere with the AP Spine measurement)

Thank you for providing us with the necessary information that will enable us to properly evaluate your bone density study today. Please return this questionnaire to the receptionist and our technician will be with you shortly.