HOLLYWOOD DIAGNOSTICS CENTER

APPOINTMENT TIME: _____ AM/ PM

PATIENT ID: _____ ACCESSION NUMBER: _____

REFERRING PHYSICIAN: _____

BONE DENSITY QUESTIONNAIRE

PATIENT NAME: _____

DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____

ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE RESPONSE

GYNECOLOGICAL HISTORY (WOMEN ONLY)

HAVE YOU HAD A HYSTERECTOMY? YES / NO

HAVE YOU ENTERED MENOPAUSE? YES / NO

MEDICATIONS

ARE YOU NOW TAKING HORMONE REPLACEMENT PILLS OR PATCHES? YES / NO

DO YOU TAKE CORTISONE, PREDNISONE OR OTHER STEROIDS FOR TREATMENT OF ASTHMA, ARTHRITIS, 0R CANCER? YES / NO

DO YOU TAKE THYROID MEDICATION? YES / NO

DO YOU TAKE CALCIUM SUPPLEMENTS? YES / NO

LIFESTYLE

DO YOU SMOKE CIGARETTES? IF YES, PACKS PER DAY? _____ YES / NO

DO YOU DRINK ALCOHOLIC BEVERAGES? YES/ NO

DO YOU DRINK BEVERAGES WITH CAFFEINE (COFFEE, TEA, COLA)? YES / NO

DO YOU EXERCISE REGULARLY? YES / NO

FRACTURES AND FALLS

HAVE YOU HAD ANY BROKEN BONES WITHIN THE LAST TEN YEARS? YES / NO

HAVE YOU HAD A HIP REPLACEMENT? WHICH ONE? _____ YES / NO

HISTORY OF OSTEOPOROSIS AND BACK PAIN

DOES ANYONE IN YOUR FAMILY HAVE OSTEOPOROSIS? YES/ NO

◯MOTHER ◯FATHER ◯SISTER ◯BROTHER

DO YOU EVER HAVE BACK PAIN? YES / NO

IS IT: ◯MILD ◯SEVERE ◯DULL ◯SHARP ◯INTERMITTENT ◯CONSTANT

ETHNICITY

◯ASIAN ◯HISPANIC ◯BLACK ◯ WHITE ◯OTHER