Bone Density Questionnaire

Patient Name: _____ Referring Physician: _____ Date: _____

Date of Birth: _____ Weight: _____ lbs. Height: _____

Answer the questions below by checking Yes or No.	Yes	No	Comment
Have you had a hysterectomy, if yes, what age?	☐	☐	
If yes, were your ovaries removed?	☐	☐	
Have you entered menopause? If yes, what age?	☐	☐	
Do you currently smoke?	☐	☐	
If no, have you had a history of smoking in the last 15 years?	☐	☐	
Do you drink alcoholic beverages regularly?	☐	☐	
Do you drink carbonated beverages regularly?	☐	☐	
Do you exercise regularly?	☐	☐	
Have you broken or fractured a bone during your adulthood? (Specify)	☐	☐	
Do you consume dairy products regularly?	☐	☐	
Do you have back pain?	☐	☐	
Does anyone in your immediate family have Osteoporosis?	☐	☐	
Do you ☐ currently have cancer or ☐ have a history of cancer?	☐	☐	
Do you ☐ currently receive or ☐ have a history of treatment with:			
☐ Chemotherapy ☐ Radiation	☐	☐	
☐ Tamoxifen, Arimidex; Femara; Aromasin	☐	☐	
Are you ☐ currently on or ☐ have a history of Hormone Replacement of any kind?	☐	☐	
Do you take Thyroid medication?	☐	☐	
Do you take Calcium supplements?	☐	☐	
Are you ☐ currently on or ☐ have a history of any type of Osteoporosis treatment? (specify)	☐	☐	
Are you ☐ currently on or ☐ have a history of any type of long-term steroid or corticosteroid treatment?	☐	☐	
Have you had any of the following conditions?			
a. Thyroid Disease	☐	☐	
b. Liver Disease	☐	☐	
c. Kidney Disease	☐	☐	
d. Arthritis	☐	☐	
e. Bowel Disease	☐	☐	

Patient Signature: _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

NOVANT HEALTH

Bone Density Questionnaire

Name / MR # / Label