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BONE DENSITY QUESTIONNAIRE

Name: _____ Date of Birth:_____ Date:_____

Ethnicity: ☐Black ☐Caucasian ☐Hispanic ☐Asian

Is there a chance that you are pregnant? ☐No ☐Yes

In the past week have you had a radiology study where barium, contrast, dye or a radioactive injection was given to you? ☐No ☐Yes

Have you ever had a bone density test? ☐No ☐Yes

If yes, Where_____ When_____

Do you have a family history of osteoporosis? ☐No ☐Yes Relationship:_____

Have either of your parents ever fractured a hip? ☐No ☐Yes

Do you smoke? ☐No ☐Yes If you smoked in the past, when did you quit? _____

Do you drink alcohol on a daily basis? ☐No ☐Yes If yes, how many drinks per day?_____

How many servings of caffeinated beverages do you drink per day?_____

Do you wear glasses or contact lenses? ☐No ☐Yes

Do you exercise for at least 150 minutes per week? ☐No ☐Yes

List all of the broken bones you have had after the age of 40:

Bone broken	How it happened	What age were you?

Have you had surgery on either hip? ☐No ☐Yes If yes, what side? ☐Right ☐Left

Have you ever had surgery on your spine? ☐No ☐Yes If yes, what type of surgery?_____

This section is for WOMEN ONLY:

Are you still menstruating? ☐No ☐Yes If yes, are your periods regular or irregular? (Please Circle)

If no, age of onset of menopause: _____ Was menopause natural or surgical? (Please Circle)

TECHNOLOGIST TO COMPLETE THIS SECTION:

Tallest Height:_____ Current Height:_____ Height Loss:_____ Current Weight:_____

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Technologist Comments:_____

Medication List:

Name	Dosage	How Often	Reason

Have you ever taken any of the following medications?

Medicine	No	Yes	How Long?	When Stopped?
Seizure Medicine?				
Medication to prevent return of cancer?				
For over or underactive thyroid				
Osteoporosis Medicine (injection or pill)				
Prednisone or Steroids				
Hormone Replacement therapy (estrogen)				
Hormone suppressing agents (Lupron, Depo Provera)				

How many servings of calcium rich foods do you average per day? _____

Do you take a calcium supplement? ☐No ☐Yes If yes, how much?_____

Do you take a vitamin D supplement? ☐No ☐Yes If yes, how much?_____

Do you have any of the following medical conditions? Check all that apply to you.

☐Hyperparathyroidism ☐High calcium Blood Levels ☐Bowel Disease:Type_____

☐Gastric Bypass ☐Low Testosterone ☐Frequent falls

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☐Eating Disorder	☐Vitamin D deficiency	☐Kidney Disease
☐Rheumatoid Arthritis	☐Osteoarthritis	☐Autoimmune Disease:_____
☐Cancer:_____	☐Chemotherapy	☐Radiation therapy
☐Liver Disease	☐Other:_____	☐Asthma/COPD/Lung disease

Medical Release of Information

I authorize Pine Hollow Partners to release any medical information that may be necessary to either medical care or processing financial benefits. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information I provided on the pages above is current and correct.

Patient Signature_____ Date_____

Patient Name (Print)_____ Date of Birth_____