Lakeside Women's Hospital
A member of the INTEGRIS Network

Bone Density Questionnaire

Name:_____ Date of Birth:_____ Height:_____

Date:_____ Sex:_____ Weight:_____ Age:_____ Ethnicity:_____

Prior Bone Density Scans: Yes: ☐ No: ☐ Date of Prior Scan:_____
Location of Prior Scan:_____

Physician(s):_____

Medical History

Please check all that apply and circle any applicable options

☐ Anorexia, Bulimia, etc.	☐ Height-Loss History: # inches _____	☐ Padget's Bone Disease	☐ Smoking: ☐ Past ☐ Current
☐ Back Pain	☐ Hysterectomy: Age:	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Cancer: Breast / Uterine / Other	☐ Last Menstrual Period / /	Previous History: ☐ Osteopenia ☐ Osteoporosis	
☐ Celiac Disease or Tropical Sprue	☐ Menopausal Age:	☐ Recurrent Falls	
☐ Insulin Dependent Diabetes	☐ Ovaries Removed	☐ Rheumatoid Arthritis	
☐ Fracture: Spine / Wrist / Hip / Ankle	Fracture was trauma related ☐ Yes ☐ No		

Family History

Please check all that apply

☐ Family History of Osteoporosis ☐ Family History of Hip Fracture - Mother or Father

Lifestyle Factors

Please check all that apply and circle any applicable options

☐ Alcoholic Beverages: NONE 0-2 daily 3 or more daily

☐ Caffeinated Beverages/day: NONE 1 2 3 ≥4

☐ Servings Calcium-Rich Food/Daily: NONE 1 2 3 ≥4

☐ Weight-bearing exercise/Number of Hours: NONE 1-2hrs/wk 3-4hrs/wk 5-7 hrs/wk

Medications

Please check all that apply and circle any applicable options	☐ Actonel	☐ Estrogen yrs	☐ Miaclcin	☐ Arimidex
☐ Calcium: NONE 500 600 1000 1200: ☐ Once Daily ☐ 2/day ☐ 3/day	☐ Alendronate	☐ Evista	☐ Prolia	☐ Diuretics
☐ Contraceptive: ☐ Pill ☐ Shot ☐ Patch ☐ Ring	☐ Atelvia	☐ Foreto	☐ Reclast	☐ Femara
☐ Hormone Replacement Therapy ☐ Compound Hormones	☐ Boniva	☐ General Multi-vitamin	☐ Other:	☐ Inhaled Steroids
☐ Herbal Supplements ☐ Other	☐ Duavee			☐ Oral Steroids – Dose _____
				☐ Tamoxifen
				☐ Thyroid

Other Medications Prescribed by a Physician:_____

Medications/herbs/vitamins not prescribed by a physician:_____