HOAG MEMORIAL HOSPITAL PRESBYTERIAN

BONE DENSITOMETRY PATIENT HISTORY QUESTIONNAIRE
Breast Care Center

Patient Name: _____ Ordering Physician: _____

Is there any chance that you could be pregnant? ☐ Yes ☐ No

Have you had a barium X-ray or an injection of X-ray dye in the last 10 days? ☐ Yes ☐ No

Have you had a CT with contrast or a Nuclear Medicine test in the last 10 days? ☐ Yes ☐ No

If you answered yes to any of the questions above, please speak to our receptionist.

Ethnicity (For WHO reference population): ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic ☐ Other: _____

Current Height: _____ Your tallest height (young adult): _____

Have you ever had a bone densitometry exam? ☐ Yes ☐ No

If yes, please state location and approximate date: _____

Have you broken any bones as an adult? ☐ Yes ☐ No

If yes, please list: _____

Have you ever fractured your spine? ☐ Yes ☐ No If yes, was it the: ☐ Cervical ☐ Thoracic ☐ Lumbar

Have you ever had spine surgery? ☐ Yes ☐ No If yes, was it the: ☐ Cervical ☐ Thoracic ☐ Lumbar

If yes, what type of surgery? ☐ Fusion ☐ Discectomy ☐ Laminectomy ☐ Laminotomy ☐ Other: _____

Have you ever fractured your femur(s)/hip(s)? ☐ Yes ☐ No If yes, was it the: ☐ Right ☐ Left ☐ Both

Have you ever had femur/hip surgery? ☐ Yes ☐ No If yes, was it the: ☐ Right ☐ Left ☐ Both

Have you ever fractured your wrist(s)/forearm(s) ☐ Yes ☐ No If yes, was it the: ☐ Right ☐ Left ☐ Both

Have you ever had wrist/forearm surgery? ☐ Yes ☐ No If yes, was it the: ☐ Right ☐ Left ☐ Both

Please list any chronic medical conditions that you have: _____

_____

Have you ever had any type of cancer? ☐ Yes ☐ No If yes, please list: _____

Do you smoke or use tobacco? ☐ Yes ☐ No If no, have you used it in the past? ☐ Yes ☐ No

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

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

For Women:

Are you still having menstrual periods? ☐ Yes ☐ No If no, at what age did they stop? _____

Have you had a hysterectomy? ☐ Yes ☐ No If yes, at what age? _____

Have you had your ovaries removed? ☐ Yes ☐ No If yes, at what age? _____

Please check Yes or No to the following indications:

Alcoholism	☐ Yes ☐ No	Hyperparathyroidism	☐ Yes ☐ No
Amenorrhea	☐ Yes ☐ No	Hyperthyroidism (overactive)	☐ Yes ☐ No
Anorexia/Bulimia	☐ Yes ☐ No	Hypothyroidism (underactive)	☐ Yes ☐ No
Anticonvulsant	☐ Yes ☐ No	Kidney Transplant	☐ Yes ☐ No
Arthritis: Osteoarthritis	☐ Yes ☐ No	Kyphosis	☐ Yes ☐ No
Psoriatic Arthritis	☐ Yes ☐ No	Osteopenia (Low Bone Mass)	☐ Yes ☐ No
Rheumatoid Arthritis	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Chemotherapy/Radiation	☐ Yes ☐ No	Parent Hip Fracture	☐ Yes ☐ No
Dementia	☐ Yes ☐ No	Steroid Use	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	If yes, chronic or as needed? _____	
Family History of Osteoporosis	☐ Yes ☐ No	If yes, inhaled or oral? _____	
GERD (Reflux)	☐ Yes ☐ No	Thyroid Medications	☐ Yes ☐ No
Graves Disease	☐ Yes ☐ No	Thyroidectomy	☐ Yes ☐ No
Hypercalcemia	☐ Yes ☐ No	Vitamin D Deficiency	☐ Yes ☐ No

Have you ever been treated with any of the following medications? ☐ Yes ☐ No

If yes:	Currently?	In the past?	For how long?
ERT/HRT (Hormone Replacement)			
Actonel/Atelvia/Risedronate			
Aredia/Intravenous Pamidronate			
Bonefos/Clodronate/Ostac			
Boniva/Ibandronate			
Evenity/Romosozumab			
Evista/Raloxifene			
Forteo/Tymlos/Abaloparatide			
Fosamax/Alendronate			
Miacalcin/Fortical/Calcitonin			
Prolia/Xgeva/Denosumab			
Reclast/Zometa/Zoledronic Acid			
Strontium			

Patient/Legal Representative Signature: _____ Date/Time: _____

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____