BONE DENSITOMETRY PATIENT HISTORY QUESTIONNAIRE
Breast Care Center

Patient Name: _____ Date of Birth: _____

Ordering Physician: _____

Is there a chance that you are pregnant? ☐ Yes ☐ No
Have you had a barium X-ray in the last 10 days? ☐ Yes ☐ No
Have you had a nuclear medicine scan or injection of an X-ray dye in the last 10 days? ☐ Yes ☐ No

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

Your: Current height: _____ Tallest height: _____ Sex: ☐ Male ☐ Female

Your ethnicity (for WHO reference population):
☐ Caucasian (White) ☐ African American (Black) ☐ Asian (including Indian, Pakistani, Bangladeshi)
☐ Hispanic ☐ Other: _____

1. Have you ever had a bone density test? ☐ Yes ☐ No
   If YES, when and where? _____
2. Have you ever broken a bone? ☐ Yes ☐ No

Bone broken	Simple fall?	If not a simple fall, please describe the circumstances	Age when this occurred

3. Have you ever had surgery on your spine, hips, legs, or arms? ☐ Yes ☐ No
   If YES, describe what type of surgery you had, and which side was affected:
   _____
   _____
4. Has a parent had a broken hip from a simple fall or bump? ☐ Yes ☐ No
5. Do you smoke or use tobacco? ☐ Yes ☐ No
6. Are you currently taking, or have you previously taken prednisone pills (cortisone)?
   ☐ Yes, currently ☐ Yes, previously ☐ No
   If YES, how long? _____ At what dose? _____mg or _____ pills each day
7. Do you have arthritis? ☐ Yes ☐ No
   If YES, is it: ☐ Osteoarthritis ☐ Psoriatic ☐ Rheumatoid
8. Do you drink 3 or more alcoholic drinks per day? ☐ Yes ☐ No

PATIENT LABEL

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9. Please list any chronic medical conditions that you have (e.g., cancer, GERD, asthma, COPD, chronic kidney disease, eating disorders, malabsorption conditions, etc.):

_____ _____

_____ _____

_____ _____

_____ _____

10. Have you been diagnosed with Hypothyroidism (underactive thyroid)? ☐ Yes ☐ No
11. Have you been diagnosed with Hyperthyroidism (overactive thyroid)? ☐ Yes ☐ No
12. Have you been diagnosed with Hyperparathyroidism/Hypercalcemia? ☐ Yes ☐ No
13. Are you currently taking, or have you previously taken any of the following medications?

Medication	No	Yes	For how long?
Medication for seizures or epilepsy			
Chemotherapy for cancer			
Androgen Deprivation Therapy (e.g., Lupron, Orgovyx, etc.)			
Medication to prevent organ transplant rejection			

14. Have you been treated with any of the following medications?

Medication	No	Yes	Currently?	If current, how long?
Hormone replacement therapy/HRT (Estrogen)				
Actonel/Atelvia (Risedronate)				
Aredia (IV Pamidronate)				
Bonefos/Ostac (Clodronate)				
Boniva (Ibandronate)				
Evenity (Romosozumab)				
Evista (Raloxifene)				
Forteo/Tymlos/Bonsity (Abaloparatide)				
Fosamax/Binosto (Alendronate)				
Miacalcin/Fortical/Calcitonin (nasal spray)				
Prolia/Bildyos/Boncresa/Bosaya/Conexxence/Enoby/Jubbonti/ Ospomyv/Osvyrti/Ponlimsi/Stoboclo/(Denosumab)				
Xgeva/Aukelso/ Bilprevda/Bomyntra/Degevma/Jubereq/Osenvelt/ Oziltus/ Wyost/ Xbryk/Xtrenbo (Denosumab)				
Reclast/Zometa/Aclasta (Zoledronic acid)				
Strontium/Protelos				

15. Do you take calcium supplements (including multivitamins, TUMS)? ☐ Yes ☐ No
16. Do you take vitamin D supplements? ☐ Yes ☐ No

For women only…

17. Are you still having a regular menstrual cycle? ☐ Yes ☐ No If NO, at what age did they stop? _____
18. Have you had a hysterectomy? ☐ Yes ☐ No
    Have you had both of your ovaries removed? ☐ Yes ☐ No If YES, at what age? _____

Patient/Legal Representative Signature: _____ Date: _____ Time: _____A.M./P.M.

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____

Reviewed By: _____ Date: _____ Time: _____A.M./P.M.

PATIENT LABEL