Northeast Radiology

BONE DENSITOMETRY PATIENT QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Age_____

1. What is your current **WEIGHT?** Pounds_____ _ What is your current **HEIGHT?** Feet _____ Inches _____

2. What is your ethnicity? ☐Asian ☐Black ☐Hispanic ☐White ☐Other

3. Have you lost any **HEIGHT?** If yes, how many inches: _____ ☐Yes ☐No

4. Any previous compression spine fractures? Which level?: _____ ☐Yes ☐No
Hip fractures? Which hip? _ _____ ☐Yes ☐No
Wrist fractures? Which arm? _____ ☐Yes ☐No

5. Do you take oral steroids (Glucocorticoids) or have you taken oral steroids longer than 3 months?
If yes, how long have you taken them?_____ ☐Yes ☐No

6. Did your mother or father ever have a hip fracture? _____ ☐Yes ☐No

7. Are you currently smoking cigarettes? _____ ☐Yes ☐No

8. Do you have a confirmed diagnosis of Rheumatoid Arthritis? _____ ☐Yes ☐No

9. Do you have one of the following disorders strongly associated with secondary Osteoporosis? Type 1 Diabetes, Osteogenesis Imperfecta, untreated Hyperthyroidism, Hypogonadism, premature menopause (<45), Chronic malnutrition, or malabsorption and chronic liver disease? _____ ☐Yes ☐No

10. Do you drink 3 or more glasses of alcohol a day? _____ ☐Yes ☐No

11. Have you had surgery to your lower back? If yes, what level? _____ ☐Yes ☐No

12. Do you currently take any osteoporotic medication? If yes, what is the name of the medication(s) and how long have you been taking them? _____ ☐Yes ☐No

13. Do you take calcium supplements? If yes, how long? _____ ☐Yes ☐No

14. Do you take hormone replacement? If yes, how long? _____ ☐Yes ☐No

15. Any family history of osteoporosis? If yes, who? _____ ☐Yes ☐No

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FOR OFFICE USE ONLY
LVA: > 65 and questions 3 – 5
FRAX: Questions 4 - 10