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

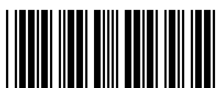
Do you take calcium supplements? ☐ Yes ☐ No If yes, how much? ______________________

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

<u>For Women</u>:
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:

Indication	Yes	No	Indication	Yes	No
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): ____