HOUSTON Methodist WEST HOSPITAL

BONE DENSITY QUESTIONNAIRE

Patient's Name (print): _____ Date: _____

Sex: MALE FEMALE

Is there a chance you are pregnant? YES NO
Have you had a barium x-ray study in the last 2 weeks? YES NO
Have you had a nuclear medicine scan or an injection of x-ray dye in the last week? YES NO
Have you had hyperparathyroidism or a high calcium level in your blood? YES NO

If you answered YES to any of the above, please speak to our receptionist immediately

Ethnicity: (check one): ___Caucasian ___Black___Aboriginal___Asian___Hispanic___Other_____

Have you ever had a bone density test? YES NO
If YES, when and where?

_____

Have you had a recent weight change? YES NO
If YES, explain:

_____

Your height: _____Your weight:_____

Have you ever broken a bone?

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

Has a parent or sibling had a broken hip from a simple fall or bump? YES NO
Has a parent or sibling had any other type of broken bone from a simple fall or bump? YES NO
How many times have you fallen in the last year? _____
Have you ever had surgery of the spine, hips, legs, or arms? YES NO
If YES, describe what type of surgery you had and which side was affected:

_____

_____

Are you currently receiving or have you previously received Prednisone pills (Cortisone)?
Yes, currently _____ Yes, previously _____ No _____
If YES, for how long? _____ What was/is your dosage? _____mg or _____pills each day.

List any chronic medical conditions you have:

_____

_____

_____

_____

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Are you currently receiving or have you previously received any of the following:

	No	Yes	How long?
Medication for seizures or epilepsy			
Chemotherapy for cancer			
Medication for prostate cancer			
Medication to prevent organ transplant rejection			

Have you ever been treated with any of the following medications:

Medication	Ever taken?	Currently taking?	If current, how long?
Hormone Replacement Therapy (Estrogen)			
Tamoxifen			
Raloxifene (Evista)			
Testosterone			
Etidronate (Didronel/Didrocal)			
Alendronate (Fosamax)			
Risedronate (Actonel)			
Intravenous Pamidronate (Aredia)			
Clodronate (Bonefos, Ostac)			
Calcitonin (Miacalcin Nasal Spray)			
PTH (Forteo)			
Zoledronic Acid (Zometa)			
Sodium Fluoride (Fluotic)			

Do you take any calcium supplements (including TUMS)? YES NO
Do you take any vitamin D supplements (including multivitamins and Halibut liver oil)? YES NO
Do you smoke? YES NO

For Women Only…

Are you still having menstrual periods? YES NO

Have you gone through menopause? YES NO
If YES, at what age? _____

Have you had both of your ovaries removed? YES NO
If YES, at what age? _____