BaylorScott&White
MEDICAL CENTER
CENTENNIAL

FRHGENE135
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BONE DENSITY QUESTIONNAIRE

Patient Name:

1. Age:______ DOB:__________ **2. Sex ☐ M ☐ F**
3. Weight__________ **4.Height_________**

Date: ___________

Have you ever had a Bone Density test?: ☐ Yes ☐ No When_____________ Where_____________

Have you had a Barium CT or X-Ray in the last 2 weeks? ☐ Yes ☐ No Exam type_______________

Race/Ethnicity: ☐ Black ☐ Caucasian ☐ Hispanic ☐ Asian

Prior Surgeries with metal pins, rods, or plates: ☐ Yes ☐ No If yes:

☐ Spine ________________ ☐ Hip: ☐ Left ☐ Right: ______________________

5. Have you ever fractured (broken) your spine, femur (hip), or wrist? ☐ Yes ☐ No (If yes, please explain)_____________
6. Do you have a family history of hip fracture? ☐ Yes ☐ No
7. Do you use tobacco products? ☐ Yes ☐ No
8. Have you ever used glucocorticoids (steroid hormones)? ☐ Yes ☐ No
9. Have you ever been diagnosed with Rheumatoid arthritis? ☐ Yes ☐ No
10. Have you ever been diagnosed with osteoporosis? If yes, was it secondary to a drug or treatment? ☐ Yes ☐ No (If yes, please explain)_____________
11. Do you consume 3 or more alcoholic drinks per day? ☐ Yes ☐ No
12. Do you have any of the following conditions/illnesses?
    ☐ Chronic Kidney Disease ☐ Hyperactive Thyroid ☐ Hypoactive Thyroid
13. Do you currently take: ☐ Calcium ☐ Vitamin D
14. Do you have a family history of osteoporosis? ☐ Yes ☐ N
15. Have you ever been diagnosed with osteopenia? ☐ Yes ☐ N
16. Have you had an endometrial ablation? ☐ Yes ☐ No
17. Have you had a partial or total hysterectomy? ☐ Yes ☐ No (If yes, please explain) ____________
18. Do you still have both ovaries? ☐ Yes ☐ No ☐ One Only
19. Have you completed menopause? ☐ Yes ☐ No When__________

Applicable to Females Only

Technologist: ____________

«PatientNumber»