



BONE DENSITOMETRY QUESTIONNAIRE

PHYSICIAN: ___ DR. TERRANCE SIMON
 ___ DR. EUGENE POGORELEC
 ___ DR. WAYNE LUTZKE

PATIENT NAME: _____ DOB: _____
(please print) (first) (middle initial) (last)

RACE: ___ Caucasian ___ Hispanic ___ Asian ___ African-American

HEIGHT _____ WEIGHT _____

MENOPAUSAL AGE: _____ HYSTERECTOMY _____

HAVE YOU EVER HAD A BONE DENSITY TEST HERE IN THIS OFFICE?
 ___ YES ___ NO

IF NOT, WHERE DID YOU HAVE YOUR LAST ONE? _____

IS THERE ANY CHANCE OF PREGNANCY? ___ YES ___ NO

HAVE YOU EVER HAD BACK SURGERY? _____

HIP SURGERY? ___ RIGHT ___ LEFT

DO YOU HAVE A FAMILY HISTORY OF OSTEOPOROSIS? _____

 IF YES WHO? _____

DO YOU SMOKE? ___ DRINK ALCOHOL? _____

EXERCISE? _____ WEIGHT BEARING? _____

HAVE YOU HAD ANY FRACTURES? _____ *(if yes, what was broken?)*

HAVE YOU EVER TAKEN HORMONE REPLACEMENT THERAPY? _____

HAVE YOU EVER HAD CHEMOTHERAPY? _____

HAVE YOU EVER BEEN ON SEIZURE MEDICATION? _____

HAVE YOU EVER TAKEN STEROID MEDICATION? _____
(prednisone, cortisone, etc)

DO YOU HAVE A HISTORY OF LOW TESTOSTERONE LEVELS? _____

DO YOU TAKE CALCIUM SUPPLEMENTS DAILY? _____

HAVE YOU HAD) ANY PROCEDURES IN THE LAST 7 DAYS THAT CONTAINED
THE FOLLOWING SUBSTANCES WHICH COULD INTERFERE WITH THE TEST?

 ___ IODINE ___ BARIUM ___ ISOTOPE
(nuclear medicine study)

PATIENT SIGNATURE: _____ DATE: _____

TECHNOLOGIST SIGNATURE: _____