Missouri Baptist MEDICAL CENTER

BJC HealthCare

BONE DENSITY QUESTIONNAIRE

(To Be Completed By Patient)

Patient Identification Label

Name: _____ **Age:** _____ **Today's Date:** _____

Sex: ☐ Female ☐ Male

Women: Indicate menopausal status:
- ☐ Still menstruating regularly
- ☐ Starting menopause
- ☐ Menstruation stopped at age _____
- ☐ Hysterectomy at age _____
  If yes, were the ovaries removed? ☐ no ☐ yes

Ethnicity (optional):
- ☐ Caucasian
- ☐ African American
- ☐ Hispanic
- ☐ Asian
- ☐ American Indian
- ☐ Other: _____

Have you had a Barium X-Ray, CT with Contrast, or Nuclear Medicine Test in the last two weeks? ☐ no ☐ yes

I am taking:

Prednisone/Cortisone ..	☐ no	☐ yes	Tamoxifen (Nolvadex) ...	☐ no	☐ yes	Reclast.....	☐ no	☐ yes
Calcium pills.....	☐ no	☐ yes	Depo-Provera	☐ no	☐ yes	Zometa.....	☐ no	☐ yes
Vitamin D.....	☐ no	☐ yes	Fosamax.....	☐ no	☐ yes	Prolia	☐ no	☐ yes
Miacalcin or Fortical.....	☐ no	☐ yes	Actonel	☐ no	☐ yes	Forteo.....	☐ no	☐ yes
Estrogen.....	☐ no	☐ yes	Atelvia.....	☐ no	☐ yes	Thyroid Pills.....	☐ no	☐ yes
Raloxifene (Evista).....	☐ no	☐ yes	Boniva	☐ no	☐ yes	Aromatase Inhibitor	☐ no	☐ yes

Have you had a diagnosis of:

Low bone density (osteopenia)	☐ no	☐ yes	Overactive parathyroid glands (hyperparathyroidism).....	☐ no	☐ yes
Osteoporosis.....	☐ no	☐ yes	Overactive Thyroid Disease.....	☐ no	☐ yes
Scoliosis	☐ no	☐ yes	Underactive Thyroid Disease.....	☐ no	☐ yes
Loss of height.....	☐ no	☐ yes			
Back surgery	☐ no	☐ yes			
Hip surgery.....	☐ no	☐ yes			

Have you broken any bones as an adult? ☐ no ☐ yes

If so, which ones: ☐ hip ☐ wrist ☐ vertebra (back)

How did this happen?

DO NOT WRITE BELOW THIS LINE

MBMC 4-3343-2621 EF

Height: _____

Weight: _____