



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 Ovaries removed at age

- If postmenopausal, indicate if you have: Hot flashes Palpitations Cold hands and feet Headaches or Insomnia Vaginal dryness or Bleeding

- I am taking: Calcium pills Calcitonin (Miacalcin) Vitamin D Estrogen Bisphosphonates (e.g., Fosamax) Raloxifene (Evista) Tamoxifen (Nolvadex)

When did you start these drugs?

- Do you have: Loss of height Known osteoporosis Other bone disorder

- I am taking or have taken for more than 6 months: Thyroid pills Phenobarbital for seizures Dilantin for seizures Steroid pills (e.g., prednisone) Heparin shots for blood clots

- Have you ever had: Transplant (kidney, heart, lung, liver) Kidney stone Overactive thyroid gland Overactive parathyroid glands Surgery for this condition? Partial or complete removal of stomach or small bowel Back surgery or hip surgery

Have you broken any bones in the past 5 years (other than due to a car accident)? If so, which ones: hip thigh lower leg wrist upper arm rib vertebra (back)

Have you ever smoked? If so, for how long

Has anyone in your family suffered from osteoporosis? If so, which relative

DO NOT WRITE BELOW THIS LINE





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

Sex: Female **Women: Indicate menopausal status:**

- Male Still menstruating regularly
- Starting menopause
- Menstruation stopped at age _____
- Hysterectomy at age _____
- Ovaries removed at age _____

If postmenopausal, indicate if you have:

- Hot flashes
- Palpitations
- Cold hands and feet
- Headaches or Insomnia
- Vaginal dryness or Bleeding

I am taking:

- Calcium pills no yes
- Calcitonin (Miacalcin) no yes
- Vitamin D no yes
- Estrogen no yes
- Bisphosphonates (e.g., Fosamax) . no yes
- Raloxifene (Evista) no yes
- Tamoxifen (Nolvadex) no yes

When did you start these drugs?

Do you have:

- Loss of height no yes
- Known osteoporosis no yes
- Other bone disorder no yes

I am taking or have taken for more than 6 months:

- Thyroid pills taking now taken in the past
- Phenobarbital for seizures taking now taken in the past
- Dilantin for seizures taking now taken in the past
- Steroid pills (e.g., prednisone) . . . taking now taken in the past
- Heparin shots for blood clots. . . . taking now taken in the past

Have you ever had:

- Transplant (kidney, heart, lung, liver) no yes
- Kidney stone no yes
- Overactive thyroid gland no yes
- Overactive parathyroid glands no yes
- Surgery for this condition? no yes
- Partial or complete removal of stomach or small bowel. . . no yes
- Back surgery or hip surgery no yes

Have you broken any bones in the past 5 years (other than due to a car accident)? no yes

If so, which ones: hip thigh lower leg wrist upper arm rib vertebra (back)

Have you ever smoked? no yes If so, for how long _____

Has anyone in your family suffered from osteoporosis? no yes

If so, which relative _____

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