COLUMBIA | RADIOLOGY

NewYork-Presbyterian

Bone Density History Questionnaire

Name: ______________________________ Today's Date: ______________________________

Patient ID: ______________________________ Sex: ☐ Male ☐ Female

Height: (in) ______________________________ Date of Birth: ______________________________

Weight: (lb) ______________________________ Referring Physician: ______________________________

Menopause Age: Ethnicity: ☐ White ☐ Black ☐ Asian ☐ Hispanic

Please inform us if it is your preference to have a chaperone in the room during your exam. ☐ I acknowledge

1) Have you had a previous hip or vertebral fracture? ☐ Yes ☐ No
2) Have you had any fractures during your adult life which did not result from significant trauma? (e.g.; auto accident?) ☐ Yes ☐ No
3) Did ether of your parents ever fracture a hip? ☐ Yes ☐ No
4) Do you smoke? ☐ Yes ☐ No
5) Have you ever taken glucocorticoids? ☐ Yes ☐ No
6) Do you have rheumatoid arthritis? ☐ Yes ☐ No
7) Do you have secondary osteoporosis? ☐ Yes ☐ No
8) Do you drink 3 of more alcoholic drinks per day? ☐ Yes ☐ No
9) Are you being treated for osteoporosis? ☐ Yes ☐ No

☐ Actonel (i.e. risedronate)	Boniva (i.e. ibandronate)
☐ Evista (i.e. raloxifene)	Forteo (i.e. parathyroid hormone)
☐ Fosamax (i.e. alendronate)	HRT (i.e. estrogen/hormone therapy)
☐ Miacalcin (i.e. calcitonin)	Protelos (i.e. strontium ranelate)
☐ Reclast (i.e. zoledronate)	Prolia (i.e. denosumab)
☐ Vitamin D	Calcium
☐ Other – Please specify: ______________	

11) Do you have any of the following medical conditions:

☐ Anorexia or Bulimia	☐ Cancer
☐ Asthma or Emphysema	☐ Celiac
☐ End stage renal disease	☐ Inflammatory bowel diseases
☐ Hyperparathyroidism	☐ Hysterectomy
☐ Any seizure disorders	☐ Other – Please specify:

12) What was your maximum height in inches? ______________
13) Do you perform weight bearing exercises regularly? ☐ Yes ☐ No
14) Do you regularly consume dairy products? ☐ Yes ☐ No
15) Do you drink caffeinated beverages? ☐ Yes ☐ No

If Female:

16) Are you or could you be pregnant? ☐ Yes ☐ No
17) At what age did your period start? ____________
18) Are you premenopausal? ☐ Yes ☐ No
19) How many full-term pregnancies have you had? __________
20) Have you ever missed your period for more than 6 months in a row? (not including pregnancy or menopause) ☐ Yes ☐ No

Patient Signature: ____ Date: ______________________