TRIANGLE ARTHRITIS & RHEUMATOLOGY ASSOCIATES

BONE DENSITOMETRY QUESTIONNAIRE

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY.
ALL OF THESE ITEMS PLAY A ROLE IN THE LIKELIHOOD OF DEVELOPING OSTEOPOROSIS & MAY AFFECT YOUR TREATMENT.

NAME: _____ TODAY'S DATE: _____
Referring Physician: _____
Sex: M ☐ F ☐ Race: White ☐ Asian ☐ Black ☐ Oriental ☐ Hispanic ☐
Height(measured by staff in our office) _____in. Weight (measured in our office) _____lb.

What was your Maximum height ? _____ft. _____in.

FEMALES ONLY: Have you gone through menopause? Yes ☐ (age at menopause _____) No ☐
Going through it now ☐
If Post-menopausal, do you currently take estrogen replacement? Yes ☐ No ☐
IF NOT, did you ever take estrogen replacement? _____ If so, for how many years?
_____
Have you ever had a hysterectomy? Full ☐ Partial ☐

ALL PATIENTS:
Describe your dairy intake (circle one): LOW ☐ (less than 1-2 servings per day)
MEDIUM ☐ (3-5 servings per day)
HIGH ☐ (more than 5 servings per day)
Do you take calcium supplements? Yes ☐ No ☐ If so, how much per day? _____mg
If you take supplements, how long have you been on calcium supplements? _____
Do you have any close blood relatives with osteoporosis or a Dowager's hump? Yes ☐ No ☐
Did either of your parents have a hip fracture? Yes ☐ No ☐

Have you ever had a fracture? Yes ☐ No ☐
If so, what part of your body? _____
How old were you when it happened? _____
Have you noticed loss in height? Yes ☐ How much? _____ No ☐
Have you had any joint replacements? Yes ☐ Which joints? _____ No ☐
Have you taken corticosteroids for any prolonged period of time? Yes ☐ No ☐
If so, for how long? _____
Have you been on Thyroid replacement? Yes ☐ if so, for _____years No ☐
Have you ever been bedridden for a long period of time? Yes ☐ (how long) _____ No ☐
Do you currently smoke? Yes ☐ No ☐ IF NOT, were you ever a smoker? Yes ☐ No ☐
Do you drink more than 2 alcoholic beverages per day? Yes ☐ No ☐
Do you have a history of significant alcohol use in the past? Yes ☐ No ☐
Please describe your level of physical activity:
Inactive ☐ Low activity ☐ Moderate activity ☐ Very active ☐
Do you take or have you taken any of the following?

FOSAMAX ☐	**How long? _____**	**ACTELVIA ☐**	**How long? _____**
MIACALCIN ☐	**How long? _____**	**EVISTA ☐**	**How long? _____**
RECLAST ☐	**How long? _____**	**PROLIA ☐**	**How long? _____**
FORTEO ☐	**How long? _____**	**BONIVA ☐**	**How long? _____**

Have you had any x-ray procedures with contrast in the past 7 days? Yes ☐ No ☐
Do you have chronic back pain? YES ☐ NO ☐
Please list any chronic medical problems you have:

_____

_____

_____