Northwest PRIMARY CARE

Bone Density Screening Questionnaire

Appointment Date & Time: _____

This confidential questionnaire helps us determine your risk factors for osteoporosis.
Please complete the form and bring it with you to your bone density screening appointment

Name: _____ DOB: _____ Age: _____ Date: _____

Primary Care Physician: _____ Height: _____ Weight: _____ Gender: F ☐ M ☐

Ethnicity: Caucasian African-American Hispanic Asian Other _____ Acct #: _____

☐ Yes ☐ No

Have you had a previous hip or vertebral fracture?	☐ Yes ☐ No	_____
Have you had any fractures during your adult life which did not result from significant trauma (e.g. auto accident)?	☐ Yes ☐ No	If yes, when and which body part? _____
Did either of your parents ever have a hip fracture?	☐ Yes ☐ No	
Do you currently smoke?	☐ Yes ☐ No	If yes, how many years? _____
Have you ever taken **oral** Glucocorticoids (e.g. Prednisone or Steroids) for 3 months or more?	☐ Yes ☐ No	If yes, How long? _____ When? _____
Do you have rheumatoid arthritis?	☐ Yes ☐ No	
Do you have secondary osteoporosis as a result of another disease/condition?	☐ Yes ☐ No	If yes, what disease/condition?
Do you drink 3 or more alcoholic drinks per day?	☐ Yes ☐ No	
Do you perform weight bearing exercise regularly?	☐ Yes ☐ No	
Do you drink more than 5 caffeinated beverages/day?	☐ Yes ☐ No	
Have you or do you take thyroid medication?	☐ Yes ☐ No	If yes, how long? _____
Do you have a family history of osteoporosis?	☐ Yes ☐ No	If yes, mother, sister, grandmother
Did you start menopause before age 45?	☐ Yes ☐ No	If yes, at what age? _____
Have you had a hysterectomy?	☐ Yes ☐ No	If yes, what age? _____ Both ovaries removed? _____
Have you had a hip replacement?	☐ Yes ☐ No	If yes, ☐ Left ☐ Right ☐ Both
Have you had surgery on your lower back?	☐ Yes ☐ No	If yes, was any hardware put in? _____
Have you had vascular or abdominal surgery?	☐ Yes ☐ No	If yes, is there any metal or mesh in the abdominal /pelvic area? _____
Is there a history of personal cancer?	☐ Yes ☐ No	If yes, what type? _____
Did you have chemotherapy?	☐ Yes ☐ No	
Did you have radiation?	☐ Yes ☐ No	

Have you had this examination before? ☐ Yes ☐ No If yes, when and where?_____

_____

Have you had an examination in the last 7 days where you had contrast material? (barium study, CAT scan, nuclear medicine study) ☐ Yes ☐ No

Please circle any medications you may be on or have taken:

Actonel (Risedronate)	How long? _____	If you quit, how long ago? _____
Fosamax (Alendronate)	How long? _____	If you quit, how long ago? _____
Boniva (Ibandronate)	How long? _____	If you quit, how long ago? _____
Reclast (Zoledronic)	How long? _____	If you quit, how long ago? _____
Prolia (Denosumab)	How long? _____	If you quit, how long ago? _____
Antacids	How long? _____	If you quit, how long ago? _____
HRT (Estrogen)	How long? _____	If you quit, how long ago? _____

Address: Northwest Therapy
12119 SE Stevens Court
Happy Valley, OR 97086
If you have questions, please call 503.353.1278.

IMPORTANT REMINDER:

DO NOT WEAR ANY CLOTHING THAT HAS A ZIPPER, BUTTONS, OR METAL.

DO NOT WEAR BRAS WITH UNDERWIRE OR METAL CLASPS (WOMEN).

ARRIVE 5-10 MINUTES EARLY.

Thank you for coming in for your osteoporosis screening!

Patient initials: _____ Date: _____ Tech initials: _____ Date: _____

POS Reorder # 2111564