St Peter's Hospital
ST PETER'S HEALTH PARTNERS

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BONE DENSITY PATIENT HISTORY QUESTIONNAIRE

Name: _____ **Sex:** **Female** **Male**

Current Height: _____ **Date of Birth:** _____

Weight: _____ **Referring Physician:** _____

Menopause Age:_____ **Ethnicity/Race:** _____

Have you had a Bone Density Study before? If so, where? _____

1. Have you had a previous hip or vertebral fracture? Yes No

1a. Have you ever had any surgery involving the spine or hips? _____

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 either of your parents ever have a hip fracture? Yes No

4. Do you smoke? Yes No

5. Have you ever taken Steroids for an extended period of time? Yes No

6. Do you have rheumatoid arthritis? Yes No

7. Do you have secondary osteoporosis (bone loss caused by a medication, treatment, or condition)? Yes No

8. Do you drink 3 or more alcoholic drinks per day? Yes No

9. Are you being treated for osteoporosis? Yes No

10. Have you ever taken any of the following medications:

- Actonel (i.e. risedronate)
- Boniva (i.e. ibandronate)
- Evista (i.e. raloxifene)
- Fortco (i.e. parathryroid 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. Have you had any of the following medical conditions:

- Vitamin D Deficiency
- Chronic Malnutrition or Malabsorption
- Liver Disease
- End Stage Renal Disease
- Anorexia or Bulimia
- Diabetes
- Organ Transplant
- Any Seizure Disorders
- Asthma or Emphysema
- Cancer
- Inflammatory Bowel Diseases
- Gastrointestinal Disease
- Hyperthyroidism (over-active thyroid)
- Hypothyroidism (under-active thyroid)
- Hyperparathyroidism
- Hysterectomy
- Skeletal Abnormalities
- Other – Please specify:_____

What is your maximum height? _____