



Montclair Breast Center
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BONE DENSITOMETRY QUESTIONNAIRE

1. Name: _____ DOB _____

2. Referring Physician _____

3. Height _____ Weight _____

4. Race: African American Asian Caucasian Native American Hispanic Other _____

5. Are you currently **pregnant** or have any reason to believe you may be? Yes No

6. Have you experienced menopause? Yes No If **yes** at what age? _____

7. Place an "X" by all that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Scoliosis (curvature of the spine) | <input type="checkbox"/> Spinal surgery or injury |
| <input type="checkbox"/> Have any spinal implants or hip prosthesis | <input type="checkbox"/> Hip surgery or injury |
| <input type="checkbox"/> Had any abdominal surgeries in the past | <input type="checkbox"/> Arthritis—what kind? _____ |
| <input type="checkbox"/> Have you fractured any bones in your adult life? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

8. Place an "X" by all that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Have a family history of osteoporosis | <input type="checkbox"/> Age 70 or older |
| <input type="checkbox"/> Have 2 or more alcoholic beverages per day | <input type="checkbox"/> Diagnosed with amenorrhea |
| <input type="checkbox"/> Chemotherapy (past or present) | <input type="checkbox"/> Have lost height |
| <input type="checkbox"/> Diagnosed with hyperthyroidism | <input type="checkbox"/> Weigh less than 127 lbs. |
| <input type="checkbox"/> Have a low dietary calcium intake | <input type="checkbox"/> Smoked in the past |
| <input type="checkbox"/> Have been diagnosed with osteoporosis | <input type="checkbox"/> Currently a smoker |
| <input type="checkbox"/> Have been diagnosed with osteopenia | |
| <input type="checkbox"/> Diagnosed with hyperparathyroidism or a parathyroid adenoma | |
| <input type="checkbox"/> Have kidney problems (dysfunction, failure, on dialysis or have had transplant.) | |

9. Place an "X" by any of the following medications/supplements:

- | | |
|---|--|
| <input type="checkbox"/> Actonel | <input type="checkbox"/> Anti-Seizure Medication(Dilantin) |
| <input type="checkbox"/> Arimidex | <input type="checkbox"/> Aromasin |
| <input type="checkbox"/> Birth Control | <input type="checkbox"/> Boniva |
| <input type="checkbox"/> Calcium Supplements | <input type="checkbox"/> Ert (Estrogen) |
| <input type="checkbox"/> Evista | <input type="checkbox"/> Calcitonin |
| <input type="checkbox"/> Fluoride Supplements | <input type="checkbox"/> Forteo |
| <input type="checkbox"/> Femara | <input type="checkbox"/> Hrt (Combo) |
| <input type="checkbox"/> Pth-1-34 | <input type="checkbox"/> Fosamax |
| <input type="checkbox"/> Synthroid | <input type="checkbox"/> Tamoxifen |
| <input type="checkbox"/> Tums | |

Have you ever had a bone densitometry performed before? Yes No
 If yes, when and where? _____

Patient's Signature _____ Date _____