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:

❑ Scoliosis (curvature of the spine)
❑ Have any spinal implants or hip prosthesis
❑ Had any abdominal surgeries in the past
❑ Have you fractured any bones in your adult life? ❑ Yes ❑ No
❑ Spinal surgery or injury
❑ Hip surgery or injury
❑ Arthritis–what kind? _____

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

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

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

❑ Actonel
❑ Arimidex
❑ Birth Control
❑ Calcium Supplements
❑ Evista
❑ Fluoride Supplements
❑ Femara
❑ Pth-1-34
❑ Synthroid
❑ Tums
❑ Anti-Seizure Medication(Dilantin)
❑ Aromasin
❑ Boniva
❑ Ert (Estrogen)
❑ Calcitonin
❑ Forteo
❑ Hrt (Combo)
❑ Fosamax
❑ Tamoxifen

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

Patient's Signature _____ Date _____