Bone Density Questionnaire

SWEDISH MEDICAL GROUP

First name: _____ **Last name**: _____ **DOB**: _____

Prior DXA scan location and date: _____

What is the tallest height you have ever been measured at: _____ (in inches)

Ethnicity and race play a role in your personal risk for fracture, please check the race you most closely identify with:

- ☐ Caucasian/white
- ☐ African American/Black
- ☐ Asian (this includes Indian, Pakistani and Bangladeshi)
- ☐ Hispanic/Latin

- ☐ Yes ☐ No Is there a chance that you are pregnant?
- ☐ Yes ☐ No Have you had a barium x-ray in the last 2 weeks?
- ☐ Yes ☐ No Have you had an injection of an x-ray dye in the last week?
- ☐ Yes ☐ No Have you taken calcium or a multi-vitamin within 4 hours of this appointment?
- ☐ Yes ☐ No Have you had a hip replacement? Right _____ Left _____ Both _____
- ☐ Yes ☐ No Have you gone through menopause (no periods for 1 year or more)? Your age at last period? _____
- ☐ Yes ☐ No Have you had **both** your ovaries removed? At what age? _____
- ☐ Yes ☐ No Have you ever fractured (broken) any bones as an adult?
  Which Bones? _____ How? _____
- ☐ Yes ☐ No Did your mother or father break or fracture a hip at any age?
  Mother _____ Father _____ Both _____ Age _____
- ☐ Yes ☐ No Are you a current _____ or former _____ smoker?
  How many cigarettes per day _____/ at your heaviest _____/ how many years _____?
- ☐ Yes ☐ No On **average** do you drink three or more alcoholic beverages **per day**?

Have you ever been diagnosed with any of the following conditions?

- ☐ Yes ☐ No Rheumatoid arthritis confirmed by a positive blood test
- ☐ Yes ☐ No Insulin dependent diabetes (Type 1)
- ☐ Yes ☐ No Osteogenesis Imperfecta (this is not Osteoporosis) as an adult
- ☐ Yes ☐ No Long-standing untreated overactive thyroid (hyperthyroidism)
- ☐ Yes ☐ No Low testosterone or Hypogonadism
- ☐ Yes ☐ No Chronic malnutrition
- ☐ Yes ☐ No Malabsorption
- ☐ Yes ☐ No Hyper***para******thyroid***ism (this is not your thyroid)
- ☐ Yes ☐ No Chronic liver disease

If you answered yes to any of the conditions above, please elaborate: _____?

_____

_____

Questions continue on other side

Have you taken any of the following medications over the last two years (if yes indicate dates below)***?***

☐ Yes ☐ No Fosamax (Alendronate) Dates: _____

☐ Yes ☐ No Actonel (Risedronate) Dates: _____

☐ Yes ☐ No Boniva (Ibandronate) Dates: _____

☐ Yes ☐ No ReClast (Zoledronate Acid) Dates: _____

☐ Yes ☐ No Zometa (Zoledronic Acid) Dates: _____

Have you taken any of the following medications over the last one year (if yes indicate dates below)***?***

☐ Yes ☐ No Estrogen pills or patches, hormone replacement pills or patches Dates: _____

☐ Yes ☐ No Evista (Raloxifene) Dates: _____

☐ Yes ☐ No Calcitonin/Miacalcin nasal spray Dates: _____

☐ Yes ☐ No Forteo (Teriparatide) by injection (shots) Dates: _____

☐ Yes ☐ No Tymlos (Abaloparatide) by injection (shots) Dates: _____

☐ Yes ☐ No Prolia (Denosumab) by injection (shots) Dates: _____

☐ Yes ☐ No Evenity (Romosozumab) by injection (shots) Dates _____

Have you ever taken any of the following medications (if yes indicate dates below)***?***

☐ Yes ☐ No Anti-seizure drugs-Dilantin (Phenytoin), Tegretol (Carbamazepine), Depakote (Valproic acid) or Phenobarbital Dates: _____

☐ Yes ☐ No Hormone blocking drugs- Arimidex (Anastrozole), Femara (Letrozole), Lupron (Leuprolide), or Aromasin (Exemestane)? Dates: _____

☐ Yes ☐ No Calcium supplements (including TUMS)? Dates: _____

☐ Yes ☐ No Vitamin D supplements? Dates: _____

☐ Yes ☐ No Prednisone 450mg or more (5mg/daily for 3 or more month's lifetime or equivalent) Dates: _____

☐ Yes ☐ No Methotrexate Dates: _____