

Bone Density Scan RISK ASSESSMENT QUESTIONNAIRE

Name: _____ Date: _____

Which doctor asked you to have this scan ? _____

Would you like another doctor to have a copy of this scan ? _____

- | | | |
|---|-----|----|
| 1. Have you broken any bones as an adult ?..... | Yes | No |
| Which ones? _____ | | |
| 2. Has a parent ever suffered a hip fracture ?..... | Yes | No |
| 3. Did you ever smoke tobacco ?..... | Yes | No |
| For how long ? _____, Year you quit ? _____ | | |
| 4. Do you drink alcohol (3+ drinks per day)..... | Yes | No |
| 5. Do you exercise ?..... | Yes | No |
| What type of exercise ? _____ | | |
| How many times per week ? _____, how long ? _____ | | |
| 6. Do you take calcium pills ?..... | Yes | No |
| Brand/dose ? _____ | | |
| 7. Do you avoid dairy products ?..... | Yes | No |
| 8. Do you drink 3 or more caffeinated beverages per day ?..... | Yes | No |
| 9. Have you lost more than 2 inches of height since age 18 ?..... | Yes | No |

(Questions 10 – 13 for women only)

- | | | |
|--|----------------|----------------------|
| 10. Did you have a hysterectomy ?..... | Yes | No |
| Were your ovaries removed ?..... | | |
| 11. Did you go through menopause ?..... | Yes | No |
| If yes, at what age ? _____ | | |
| 12. Do you take estrogen or progesterone ?..... | Yes | No |
| If yes, what kind ? _____ | | |
| 13. Is it possible that you might be pregnant ?..... | Yes | No |
| 14. Have you had surgery on your hip, spine, or wrist ?..... | Yes | No |
| 15. Do you take steroids regularly ?..... | Yes | No |
| If yes, what is the dose ? _____ | | |
| 16. Do you have hyperthyroidism ? (overactive thyroid)..... | Yes | No |
| 17. Do you take thyroid medicines regularly ?..... | Yes | No |
| 18. Do you have hyperparathyroidism ?..... | Yes | No |
| 19. Do you have cancer ?..... | Yes | No |
| Which kind ? _____ | | |
| 20. Do you have an eating disorder ?..... | Yes | No |
| 21. Circle - if you take any of these medicines: | | |
| Seizure pills | Water pills | Lithium |
| Chemotherapy for cancer | | |
| 22. Circle – if you have any of the following conditions: | | |
| Liver disease | Kidney disease | Rheumatoid Arthritis |
| Part of stomach removed | | |
| 23. Circle – if you currently take any of these medicines: | | |
| Fosamax | Actonel | Boniva (pill or IV) |
| Evista | Miacalcin | IV pamidronate |
| Forteo | | |
| IV Reclast | | |