Dartmouth Health

Dartmouth Hitchcock Medical Center
Department of Radiology

BONE DENSITY QUESTIONNAIRE

Please complete and fax to: (603) 640-1944 **For telephone assistance: (603) 653-9388**

PATIENT INFORMATION

Patient Name: ____________________ **DOB:** __________ **MRN:** ____________________

Sex: ☐ Female ☐ Male ☐ Transgender / Non-Conforming **Height:** __________' __________"

Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other: ______________ **Age:** ________ **Weight*:** __________

Current Medications: ____

MENOPAUSE – WOMEN ONLY

Question		
Are you post-menopausal (periods have stopped completely)? How old were you when you had your last period? ____________________ Was your menopause caused by: ☐ Surgery ☐ Chemotherapy ☐ Radiation Therapy ☐ Natural	☐ Yes	☐ No
Are you pre-menopausal (still having periods)?	☐ Yes	☐ No
If yes, are your periods regular?	☐ Yes	☐ No
Is there a chance you could be pregnant?	☐ Yes	☐ No

RISK FACTORS FOR OSTEOPOROSIS - ALL

Question		
Do you drink more than three (3) units of alcohol per day?	☐ Yes	☐ No
Did either of your parents ever have a hip fracture? ☐ One ☐ Both	☐ Yes	☐ No
Have you fractured any bones as an adult? If yes, which bone(s)? ____________________ When? __________	☐ Yes	☐ No
Have you ever had prior surgery on your: ☐ Hip ☐ Spine ☐ Forearm When? __________	☐ Yes	☐ No
Have you ever been diagnosed with rheumatoid arthritis?	☐ Yes	☐ No
Have you ever been diagnosed with hyperparathyroidism?	☐ Yes	☐ No
Do you have Type 1 or Type 2 Diabetes?	☐ Yes	☐ No
Do you have Osteogenesis Imperfecta?	☐ Yes	☐ No
Do you have Chronic Liver Disease?	☐ Yes	☐ No
Do you smoke tobacco or have you in the past? If so, for how long? ______________ (years)	☐ Yes	☐ No
Have you taken oral or intravenous prednisone, testosterone or steroids for more than 3 months?	☐ Yes	☐ No
Have you lost more than 2 inches of height since high school?	☐ Yes	☐ No
In the last seven (7) days, have you had: ☐ X-Ray with Barium ☐ CT Scan with Contrast ☐ Nuclear Medicine Test	☐ Yes	☐ No

OSTEOPOROSIS MEDICATION – ALL (please check all that apply)

Medication	Yes	No	Duration		Comments
Fosamax (alendronate)	☐ Yes	☐ No	☐ Currently	☐ Past	
Actonel (risedronate)	☐ Yes	☐ No	☐ Currently	☐ Past	
Boniva (ibandronate)	☐ Yes	☐ No	☐ Currently	☐ Past	
Reclast (zolendronic acid)	☐ Yes	☐ No	☐ Currently	☐ Past	
Zometa (zolendronic acid)	☐ Yes	☐ No	☐ Currently	☐ Past	
Miacalcin (calcitonin)	☐ Yes	☐ No	☐ Currently	☐ Past	
Evista (raloxifene)	☐ Yes	☐ No	☐ Currently	☐ Past	
Testosterone	☐ Yes	☐ No	☐ Currently	☐ Past	
Anastazole (Arimidex)	☐ Yes	☐ No	☐ Currently	☐ Past	
Letrozole (Femera)	☐ Yes	☐ No	☐ Currently	☐ Past	
Hormone replacement	☐ Yes	☐ No	☐ Currently	☐ Past	
Tamoxifen	☐ Yes	☐ No	☐ Currently	☐ Past	
Aredia (IV Pamidronate)	☐ Yes	☐ No	☐ Currently	☐ Past	
Miacalcin Nasal Spray	☐ Yes	☐ No	☐ Currently	☐ Past	
Forteo (teriparatide)	☐ Yes	☐ No	☐ Currently	☐ Past	
Exemestane (Aromasin)	☐ Yes	☐ No	☐ Currently	☐ Past	
Prolia (denosumab)	☐ Yes	☐ No	☐ Currently	☐ Past	