### BONE DENSITY QUESTIONNAIRE

#### PATIENT INFORMATION

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

**Patient Name:** ___________________  
**DOB:** __________  
**MRN:** __________

**Sex:**  
- [ ] Female  
- [ ] Male  
- [ ] Transgender / Non-Conforming  
**Height:** __________' _________"

**Race:**  
- [ ] White  
- [ ] Black  
- [ ] Hispanic  
- [ ] Asian  
- [ ] Other: __________________  
**Age:** _________  
**Weight:** _________

**Current Medications:**

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### MENOPAUSE – WOMEN ONLY

- **Are you post-menopausal (periods have stopped completely)?**  
  - [ ] Yes  
  - [ ] No

- 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?  
- Is there a chance you could be pregnant?  
  - [ ] Yes  
  - [ ] No

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### RISK FACTORS FOR OSTEOPOROSIS - ALL

- **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

- **Have you fractured any bones as an adult?**  
  - [ ] Yes  
  - [ ] No

- If yes, which bone(s)? __________________ When? ________________

- **Have you ever had prior surgery on your:**  
  - [ ] Hip  
  - [ ] Spine  
  - [ ] Forearm  
  - [ ] Other: __________________ 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

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### OSTEOPOROSIS MEDICATION – ALL (please check all that apply)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Yes</th>
<th>No</th>
<th>Currently</th>
<th>Past</th>
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</thead>
<tbody>
<tr>
<td>Fosamax (alendronate)</td>
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<td>Actonel (risedronate)</td>
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<td>Boniva (ibandronate)</td>
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<tr>
<td>Reclast (zoledronic acid)</td>
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<tr>
<td>Zometa (zoledronic acid)</td>
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<td>Miacalcin (calcitonin)</td>
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<td>Evista (raloxifene)</td>
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<td>Testosterone</td>
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<td>Anastazole (Arimidex)</td>
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<td>Letrozole (Femara)</td>
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<td>Hormone replacement</td>
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<td>Aredia (IV Pamidronate)</td>
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<td>Miacalcin Nasal Spray</td>
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<td>Exemestane (Aromasin)</td>
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<td>Prolia (denosumab)</td>
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