ARYA STANA
BONE & BREAST CARE

BONE DENSITY QUESTIONNAIRE

Date:_____ **Referring Doctor:** _____

Name:_____DOB:_____ Age:_____

Sex: M / F Height: _____Weight: _____

Menopausal Status: Pre / Peri / Post Age Menopause began: _____

Previous Bone Density Examination: Y / N Date:_____

Family history of Osteoporosis: Y / N _____

Do you have Osteoporosis? Y / N _____

Current treatment for Osteoporosis: _____

Have you had a previous hip or vertebral fracture? Y / N_____

Have you had any fractures during your adult life which did not result from significant trauma? Y / N

_____

Have you been immobilised for a period of time due to illness? Y / N _____

Have you lost more than 3cm in height in recent years? Y / N _____

Previous Surgery

Lumbar Spine: Y / N _____

Hips: Y / N _____

Hysterectomy: Y / N _____

Current Medication:

Hormone Replacement Therapy: Y / N Oral Contraceptive Pill: Y / N Cortisone: Y / N

Vitamin D: Y / N Calcium: Y / N

Do you have any of the following medical conditions?

Anorexia or Bulimia: Y / N _____

Asthma or Emphysema: Y / N _____

Cancer: Y / N _____

End Stage Renal Disease: Y / N _____

Hyperparathyroidism: Y / N _____

Inflammatory Bowel Disease: Y / N _____

Rheumatoid Arthritis: Y / N _____

Seizure Disorders Y / N _____

Other – Please Specify: _____

Have you had any abdominal or pelvic x-rays requiring oral contrast in the last 7 days? Y / N

Do you exercise regularly? Y / N

Do you consume dairy products regularly? Y / N

Do you smoke? Y / N <10_____10-20_____20+_____

Alcohol consumption: Nil / Mild / Moderate / Heavy