



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