

BONE DENSITY QUESTIONNAIRE

Date: _____ Referring Doctor: _____

Title: _____ Name: _____ Surname: _____

ID number: _____ DOB: _____ Age: _____

Sex: M / F

Previous Bone Density Examination: Y / N Date: _____

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

At what age did your period start? _____

How many full-term pregnancies have you had? _____

Have you missed your periods for more than 6months in a row (excl. pregnancy or menopause)? Y / N

Family history of Osteoporosis: Y / N _____ Do you have Osteoporosis? Y / N _____

Current treatment/medication 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

Did either of your parents ever have a hip fracture? Y/N

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

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

Previous Surgery

Lumbar Spine or 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 Diabetes: 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/pelvic scans requiring oral contrast in the last 7 days? Y / N

Do you exercise regularly? Y / N Do you perform weight bearing exercises regularly? Y / N

Do you consume dairy products regularly? Y / N

Do you drink caffeinated beverages? Y / N

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

Alcohol consumption: Nil / Mild / Moderate / Heavy (3+ drinks per day)