EASTERN RADIOLOGISTS

Breast Imaging Center | 252.754.5227 | Mon–Fri 8am–5pm • Tues 8am–7pm
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Patient Name _____ DOB ___ /___ /___ Date ___ /___ /___ MRN _____

QUESTIONNAIRE: BONE DENSITY

Referring Pysician_____ Sex M F

Menopause Age _____ Ethnicity_____

Current Weight (lb) _____ Current Height (in) _____

Previous Bone Density Test Performed? YES NO When? _____ Where?_____

1. Have you had a previous hip or vertebral fracture? YES NO
2. Have you had any fractures during your adult life which did not result from signicant trauma (e.g. auto accident)? YES NO
3. Did either of your parents ever have a hip fracture? YES NO
4. Do you smoke? YES NO
5. Have you ever taken glucocorticoids? YES NO
6. Do you have rheumatoid arthritis? YES NO
7. Do you have secondary osteoporosis? YES NO
8. Do you drink 3 or more alcoholic drinks per day? YES NO
9. Are you being treated for osteoporosis? _____ YES NO
10. Do you perform weight bearing exercise regularly? YES NO
11. Have you ever taken any of the following medications?

- ☐ Actonel
- ☐ Evista
- ☐ Fosamax
- ☐ Miacalcin
- ☐ Reclast
- ☐ Vitamin D
- ☐ Other (please specify)
- ☐ Boniva
- ☐ Forteo
- ☐ HRT (hormone therapy)
- ☐ Protelos
- ☐ Prolia
- ☐ Calcium
- ☐ Steroids (longer than 3 months)

12. Do you have any of the following medical conditions:?

- ☐ Anorexia/Bulimia
- ☐ Asthma/Emphysema
- ☐ End Stage Renal Disease
- ☐ Hyperparathyroidism
- ☐ Any seizure disorder
- ☐ Cancer
- ☐ Inflammatory Bowel Disease
- ☐ Hysterectomy

IF FEMALE:

13. At what age did your period start?_____

Are you premenopausal?? YES NO

By signing below, I give permission for any prior studies to be obtained for comparison with todays study.

Patient Signature _____ Technologists _____