Name:
DOB:
Chart:
Age:
Date:

OSNC
Orthopaedic Specialists of North County

BONE DENSITY QUESTIONNAIRE

NAME _____ **TODAY'S DATE** _____
PATIENT ACCT# _____ **SEX** _____ **DOB** _____
CURRENT HEIGHT _____ **WEIGHT** _____ **REFERRING PHYSICIAN** _____
When was your last Bone Density Study? _____ **ETHNICITY** _____

Please answer YES or NO

YES	NO		
☐	☐	1. Have you had any fractures during your adult life?	
☐	☐	2. Did either of your parents ever have a hip fracture?	
☐	☐	3. Do you smoke?	
☐	☐	4. Have you ever taken Glucocorticoids? Or steroid therapy?	
☐	☐	5. Do you have rheumatoid arthritis? Or Auto Immune disorder?	
☐	☐	6. Do you have secondary osteoporosis?	
☐	☐	7. Do you drink 3 or more alcoholic drinks per day?	
☐	☐	8. Do you have a family history of Osteoporosis?	

Have you ever taken any of the following medications?

YES	NO			YES	NO		
☐	☐	Actonel	dose	☐	☐	Boniva	dose
☐	☐	Evista	dose	☐	☐	Forteo	dose
☐	☐	Fosamax	dose	☐	☐	Vitamin D	dose
☐	☐	Miacalcin	dose	☐	☐	Calcium	dose
☐	☐	Reclast	dose	☐	☐	Hormone Replacement Therapy	dose
☐	☐	Other	dose				

Do you have any of the following medical conditions?

☐ Anorexia or Bulimia ☐ Any Seizure Disorders ☐ End stage renal disease ☐ Inflammatory bowel disease
☐ Asthma or Emphysema ☐ Cancer ☐ Hyperparathyroidism ☐ Hysterectomy

What was your maximum height? _____
Do you perform weight bearing exercise regularly? _____
Do you consume dairy products regularly? _____
Do you drink caffeinated beverages? _____

For Women Only

Do you think you might currently be pregnant? _____
Are you still menstruating? _____ If no, at what age did you go through menopause? _____
Have you had a hysterectomy? _____ **Partial** **Complete** If yes, what year _____
Were your ovaries removed? _____ Are you currently taking hormone pills? _____