Name:
DOB:
Chart:
Age:
Date:





BONE DENSITY QUESTIONNAIRE

PATIENT ACCT# SEX DOB CURRENT HEIGHT WEIGHT REFERRING PHYSICIAN When was your last Bone Density Study? ETHNICITY Please answer YES or NO YES NO 2 Did either of your parents ever have a hip fracture? 3 Do you smoke? 3 Do you smoke? 3 5 5 Do you have theumatoid arthritis? Or Auto Immune disorder? 6 Do you have secondary osteoporosis? 7 To by ou drink 3 or more alcoholic drinks per day? 8 Bo you have a family history of Osteoporosis? Have you ever taken any of the following medications? YES NO Evista dose dose dose Miacalcin dose dose dose Miacalcin dose dose Hormone Replacement Therapy dose dose Other dose dose dose Do you have any of the following medical conditions? Mean dose endose Do Cher dose do	ATE		
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Do you perform weight bearing exercise regularly?			
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