Bone Density Questionnaire

HENDERSON&WALTON
WOMEN'S CENTER, P.C.

For office use only: Height: *Weight:*

Physician: ***Office Location:***

Name: Address: City/Zip

Birthdate: Phone #:

Please select one that applies:

Ethnicity:

Is there a chance you are pregnant?

Have you ever had a Bone Density (DEXA) Scan before?

Where? When? What were the results?

HISTORY

Have you had a Hysterectomy?

If yes, were both ovaries removed? What age or what year?

Are you on hormone replacement therapy in any form? How long?

Have you had Breast Cancer? What year?

Have you gone through menopause? If so, what age did you begin?

Have you had Cancer of the Uterus (womb)?

Have you fractured any bones as an adult?

Do you have a family history of osteoporosis?

Has a Parent or Sibling broken a hip or vertebra from a simple bump or fall?

Do you currently smoke? Have you smoked in the past?

Do you drink 3 or more alcoholic beverages per day?

Please note any medications you are currently taking:

Anticonvulsants	Tamoxifen	Vitamin D
Diuretics (Lasix,etc.)	Thyroid Medication	Calcium
Forteo	Fosamax (Alendronate)	Reclast
Actones (Risidronate)	Depo-Provera	Miacalcin (Calcitonin)
Boniva	Evista (Raloxifene)	

Long-Term Steroids (Prednisone, Cortisone, etc.)

Other:

Please note any of the following conditions or procedures you have had:

Hyperthyroidism (overactive thyroid gland)	Cirrhosis of the liver
Kidney disease	Blood Clots
Eating disorder (anorexia, bulimia, etc.)	Hip Replacement (LEFT, RIGHT or BOTH) .
Part of stomach removed	Gastric Bypass/Lap Band
Spine Surgery (UPPER, MIDDLE,or LOWER)	Rheumatoid Arthritis