Bone Density Questionnaire

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

For office use only: Height: *Weight:*

Physician: Select One *Office Location:* Select One

Name: Address: City/Zip

Birth date: mm/dd/yyyy Phone #:

Please select one that applies:

Ethnicity: Select One

Is there a chance you are pregnant? No

Have you ever had a Bone Density (DEXA) Scan before? No

Where? When? What were the results?

HISTORY

Have you had a Hysterectomy? No

If yes, were both ovaries removed? No What age or what year?

Are you on hormone replacement therapy in any form? No How long?

Have you had Breast Cancer? No What year?

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

Have you had Cancer of the Uterus (womb)? No

Have you fractured any bones as an adult? No

Do you have a family history of osteoporosis? No

Has a Parent or Sibling broken a hip or vertebra from a simple bump or fall? No

Do you currently smoke? No Have you smoked in the past? No

Do you drink 3 or more alcoholic beverages per day? No

Please note any medications you are currently taking:

- ☐ Anticonvulsants
- ☐ Diuretics (Lasix,etc.)
- ☐ Forteo
- ☐ Actones (Risidronate)
- ☐ Boniva
- ☐ Tamoxifen
- ☐ Thyroid Medication
- ☐ Fosamax (Alendronate)
- ☐ Depo-Provera
- ☐ Evista (Raloxifene)
- ☐ Vitamin D
- ☐ Calcium
- ☐ Reclast
- ☐ Miacalcin (Calcitonin)
- ☐ Long-Term Steroids (Prednisone, Cortisone, etc.)
- ☐ Other: _____

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

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

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to Henderson & Walton Women's Center

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