Accession#	MR#

OSTEOPOROSIS RISK QUESTIONNAIRE

Date:

Technologist / Initials:

Name: ______________________ Height: Weight:

Age: ________ Sex: ________ DOB: ______________

Race: White Black Asian Hispanic Other: ______________

Ordering Dr: ______________________

Have you had a bone density scan before? Yes No

When and where was your previous bone density performed? Date: ______________

Location:

1. Have you had a barium study, CT scan or Nuclear Medicine scan within the last 2 weeks?
   Yes No
2. Have you had any IV contrast studies during the last week? Yes No

   If you answered yes to questions 1 or 2, Stop and return this form to the front desk.
3. Have you taken a calcium pill today? Yes No

Hormone Status Assessment (for women only)

Have you gone through menopause? (no periods for 12 months? Yes No

At what age? ______________

Was your menopause Natural Treatment(chemo) Surgical (removal of ovaries)

How many periods did you have per year? 12 5-12 less than 6

Have you taken estrogen, hormone replacement since menopause? Yes No

Are you on estrogen now? Yes No Date last taken:

Risk Factors (Men & Women)

Family members with osteoporosis ? Yes No Who: ______________

Did your parents have a Hip Fracture (Broken hip)? Yes No

Have you broken/fractured any bones since age 40? Yes No

Vertebra(spine) Y N **Femur(hip)** Y N **Forearm (wrist)** Y N Other: ______________

Did these occur with minor trauma fall from standing height? Yes No

Have you fallen in the last year? Yes No How often: ______________

What was your tallest height? ______________ What is your height now? ______________

Have you weighed less that 127lbs since age 18? Yes No

Did you ever smoke? Yes No Are you currently smoking? Yes No

Do you drink alcohol (more than 14 drinks/week)? Yes No

How many cups of caffeinated coffee, tea or soda do you drink per day? ______________

Do you exercise? Yes No

OVER →

<u>Have you ever had any of the following conditions:</u>

Condition			Condition		
Rheumatoid Arthritis	Y	N	Radiation Therapy	Y	N
Lupus (SLE)	Y	N	Chemotherapy	Y	N
Dialysis	Y	N	Overactive Thyroid	Y	N
Chronic Kidney Disease	Y	N	Hyperparathyroid	Y	N
Kidney Stones	Y	N	Diabetes (Insulin)	Y	N
Crohn's Disease	Y	N	Cushing's Syndrome	Y	N
Celiac Disease	Y	N	Hypogonadism	Y	N
Ulcerative Colitis	Y	N	Breast Cancer	Y	N
Lactose Intolerance	Y	N	Multiple Myeloma	Y	N
Anorexia/disordered eating	Y	N	Osteogenesis Imperfecta	Y	N
Chronic Liver Disease	Y	N	Asthma	Y	N
Gastrectomy	Y	N	Wegener's Granulomatosis	Y	N
Bariatric Surgery	Y	N	Paget's Disease	Y	N
Vit D Deficiency	Y	N	Spine Surgery	Y	N
			Hip Surgery	Y	N

Have you had an organ transplant? Y N Organ? ____________ When? ______________

Are you being evaluated for an organ transplant? Y N

Medications (please circle Y if you have ever taken any of the following)

Medication					
Calcium Supplement	Y	Currently	Past	Date	N
Vit D Supplement	Y	Currently	Past	Date	N
Multivitamin	Y	Currently	Past	Date	N
Miacalcin (calcitonin)	Y	Currently	Past	Date	N
Evista (Raloxifene)	Y	Currently	Past	Date	N
Tamoxifen (post menopause)	Y	Currently	Past	Date	N
Toremifene, Femaralle, Lasofoxifene (Fablyn)	Y	Currently	Past	Date	N
Etidronate (Didronal)	Y	Currently	Past	Date	N
Fosamax (Alendronate)	Y	Currently	Past	Date	N
Actonel (Risedronate)	Y	Currently	Past	Date	N
Aradia (Pamidronate)	Y	Currently	Past	Date	N
Boniva (Ibandronate)	Y	Currently	Past	Date	N
Zometa, Reclast, Aclasta (Zolendronate)	Y	Currently	Past	Date	N
Forteo (PTH)	Y	Currently	Past	Date	N
Prolia, Xgeva (Danosumab)	Y	Currently	Past	Date	N
Seizure medicine	Y	Currently	Past	Date	N
Depo-Provera	Y	Currently	Past	Date	N
Aromatese Inhibitor (Armidex, Aromasin, Femara)	Y	Currently	Past	Date	N
Tamoxifen (premenopause)	Y	Currently	Past	Date	N
Synthroid (thyroid medicine)	Y	Currently	Past	Date	N
Lupron, Casidex	Y	Currently	Past	Date	N
Prograf (Tacrollmus)	Y	Currently	Past	Date	N
Cyclosporin	Y	Currently	Past	Date	N
Rapamycin	Y	Currently	Past	Date	N
Birth control pills	Y	Currently	Past	Date	N
Prednisone (steroids) Oral or Inhaled	Y	Currently	Past	Date	N

If you are taking Prednisone currently Dose: ____________ How long: ____________

For what condition: ____

Are you taking any other bone therapies?

Patient Signature: ________________________________ Date: ________________________

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