NEW YORK RADIOLOGY PARTNERS

Kingsway Diagnostic
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Grand Radiology
P: 212.925.9788 F: 212.925.1488

Midtown Medical Pavilion
P: 212.590.2900 F: 212.523.7318

Central Park Women's Imaging
P: 212.590.5500 F: 212.523.4857

Bone Mineral Density Questionnaire

Name: ____

Today's Date: ___/___/______ **Date of Birth:** ___/___/______

Sex: ☐ **Male** ☐ **Female**

Ethnic Origin: ☐ African-American ☐ White, Caucasian ☐ Hispanic ☐ Asian ☐ Other

Please check the appropriate answer:

	Yes	**No**
Gynecological History		
1. Have you gone through menopause?	_____	_____
2. Have you had a hysterectomy?	_____	_____
3. Have you had your ovaries removed?	_____	_____
4. Absence of menstruations (i.e. loss of period other than pregnancy or menopause)?	_____	_____
5. Do you take hormone therapy in any form at this time?	_____	_____

If so, what type? (Circle one that applies.) 1. Premarin 2. Estrogen 3. Birth Control

Medical History

	Yes	No
1. Have you ever had a Bone Density (DXA) scan before?	_____	_____

If so, when? _______________ Where? ______________

	Yes	No
2. Do you have a family history of Osteoporosis?	_____	_____
3. Have you taken Cortisone or Prednisone orally for over 3 months?	_____	_____
4. Do you take any medication for raising bone density?	_____	_____

☐ Fosamax/Alendronate ☐ Fosamax D ☐ Boniva ☐ Actonel ☐ Evista

☐ Zometa ☐ Reclast

If so, how long?_________________________________

5. Do you take supplemental calcium? ☐ 1000 mg ☐ 500 mg ☐ None

6. Do you take supplemental vitamin D? ☐ Yes ☐ No If so, How much? __________

	Yes	No
7. Have you had hip replacement surgery?	_____	_____

If so, which one? ______________________________

	Yes	No
8. Have you had surgery on your lower back?	_____	_____

Other Medical conditions: (Check all that apply)

☐ Personal history of Osteoporosis

☐ Hyperthyroid (overactive thyroid)

☐ Hypothyroid (underactive thyroid)

☐ Eating disorder (Anorexia/bulimia)

☐ Celiac Disease

☐ Chronic steroid use, type and duration:

☐ Kidney disease

☐ Parathyroid disorder

☐ Rheumatoid arthritis

☐ Asthma

☐ Hypothalamic amenorrhea

____

Current Height: ___________ Previous Height: ____________ Current Weight: _______