Mountainview Medical Imaging
Bone Density Questionnaire

Patient Name _____ Date _____

Date of Birth _____ Height _____ Weight _____

Gynecologic History (women only)

Are (were) your periods regular between the ages of 18 and 40 ? YES NO
Did you ever have intervals with few or no bleeding cycles,other than during pregnancy?
YES NO
Age_____ Length of time_____

Have you had a hysterectomy? YES NO
If yes,what year_____ Were your ovaries removed?_____

Have you entered menopause? YES NO
If yes, what year?_____

Medications

Are you taking hormone replacement pills or using patches? YES NO
Do you take cortisone,prednisone, or other steroids for treatment of asthma, arthritis, or cancer?
YES NO
Do you ever take sleeping pills? YES NO
If yes, how often? _____

Lifestyle

Do you take thyroid medication? YES NO
Do you smoke cigarettes? Pks/day_____ YES NO
Do you drink alcoholic beverages? Drinks/day_____ YES NO
Do you drink carbonated beverages? Cups/day _____ YES NO
Do you exercise regularly? Amount/day_____ YES NO

Fractures

Have you ever broken any bones? YES NO
If yes what year_____ what bone did you break? _____

History of osteoporosis and back pain

Does anyone in your immediate family have ostoporosis? YES NO
Do you ever have back pain? YES NO