

BAY AREA OBSTETRICS & GYNECOLOGY, P.A.

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BONE DENSITY QUESTIONNAIRE

- 1) Name: \_\_\_\_\_ 2) Today's Date: \_\_\_\_\_
- 3) Gender: Male or Female      4) Date of Birth: \_\_\_\_\_
- 5) Ethnicity: Black/White/Hispanic/Asian/Other
- 6) Height: \_\_\_\_\_ 7) Weight: \_\_\_\_\_
- 8) Referring Doctor: \_\_\_\_\_
- 9) Social Security #: \_\_\_\_\_
- 10) LMP: \_\_\_\_\_ is there any chance you may be pregnant? Yes or No  
If YES you will be required to take a pregnancy test and reschedule your appointment.
- 11) Have you had this examination before? Yes or No. If so, at which medical facility? \_\_\_\_\_
- 12) Are you right or left-handed? Right or Left
- 13) Have you had a hip replacement surgery? Yes or No  
If so, which hip was it performed on? Right/Left/Both
- 14) Have you had any surgery on your lower back? Yes or No  
If so, which procedure(s)? Please List: \_\_\_\_\_  
\_\_\_\_\_
- 15) Do you have a known curvature (scoliosis) of your spine? Yes or No

16) Have you had any examinations within the past 7 days where you were injected or ingested a contrast material, i.e. barium nuclear meds? If so, which exam?

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17) Do you have family history of Osteoporosis? Yes or No

18) Do you take any medications? If so, please list: \_\_\_\_\_

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19) Are you post-menopausal? If so, at what age did menopause occur? \_\_\_\_\_

20) Do you take calcium supplements? Yes or No  
If so, how often? \_\_\_\_\_

21) Have you had a hysterectomy? Yes or No  
If so, partial or complete? Year: \_\_\_\_\_

22) Are you on hormone replacement therapy? Yes or No  
If so, number of years on estrogen \_\_\_\_\_

23) Do you have any perceived height loss? Yes or No

24) Do you or have you taken corticosteroids? Yes or No

25) Do you exercise regularly? Yes or No

26) Do you drink alcohol? Yes or No

27) Do you smoke? Yes or No

28) Do you drink coffee? Yes or No

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Technologist Signature: \_\_\_\_\_ Date: \_\_\_\_\_