STEPHEN FALK, MD, FACOG
MARY POAG, MD, FACOG
LAUREN MILLET, MD, FACOG

LAKEISHA DEMERSON, MD, FACOG
CAROLYN KENNEY, DO, FACOG
MELANIE CHRISTOFFERSON, DO, FACOG

Bay Area OB/GYN

Diplomates of The American Board of Obstetrics and Gynecology
17 PROFESSIONAL PARK, WEBSTER, TX 77598
281-332-9511 (telephone) | 281-332-6685 (fax) | www.baobgyn.com

BONE DENSITY QUESTIONNAIRE

Date: _____

1. Name: _____ Date of birth: _____

2. Height: _____(inches) 3. Weight: _____(pounds)

4. LMP (last menstrual period): _____ Is there any chance you may be pregnant? ☐ yes ☐ no

5. Have you had this examination done before? ☐ yes _____ (please list when and where) ☐ no

6. Are you left or right handed? ☐ left ☐ right

7. Have you had hip replacement surgery? ☐ yes _____ (please list which side) ☐ no

8. Have you had any surgery on your lower back? ☐ yes_____ (please list when and where) ☐ no

9. Do you have any known curvature (scoliosis) of your spine? ☐ yes ☐ no

10. Have you had any examinations within the past 7 days where you were injected or ingested a contrast material (i.e. barium nuclear meds? ☐ yes _____ (please list which type of exam) ☐ no

11. Do you have a family history of osteoporosis? ☐ yes ☐ no

12. Please list any medications that you take (contraception, supplements, vitamins included):

_____

_____

13. Are you postmenopausal? ☐ yes _____(please list age of menopause) ☐ no

14. Do you take a calcium supplement? ☐ yes ☐ no

15. Have you had a hysterectomy? ☐ yes _____ (please indicate whether not you had your ovaries removed) ☐ no

16. Are you on any kind of hormone replacement therapy? ☐ yes _____(please list) ☐ no

17. Do you have any perceived height loss? ☐ yes ☐ no

18. Do you exercise regularly? ☐ yes ☐ no

19. Do you drink coffee? ☐ yes ☐ no

20. Have you had a fragility fracture (fracture occurring spontaneously or from trauma which in a healthy individual would not have resulted in a fracture)? ☐ yes _____(please provide details including age) ☐ no

21. Have either of your parents had a fractured hip? ☐ yes ☐ no

22. Do you currently smoke? ☐ yes ☐ no

23. Do you or have you taken corticosteroids (yes if exposed for >3 months at a dose equivalent to prednisolone 5mg daily or more)? ☐ yes ☐ no

24. Have you ever been diagnosed with rheumatoid arthritis (answer "no" if you have osteoarthritis)? ☐ yes ☐ no

25. Do you have a disorder that is strongly associated with osteoporosis (examples: type 1 diabetes, osteogenesis imperfecta, untreated hyperthyroidism, hypogonadism or premature menopause <45 years old, chronic malnutrition or malabsorption, chronic liver disease)? ☐ yes _____ (please specify) ☐ no

26. Do you drink more than 3 alcoholic drinks a day? ☐ yes ☐ no

Patient signature: _____ Date: _____

Technologist signature: _____ Date: _____

Office use only:

FRAX score calculated ☐ yes, printed and attached to chart (if osteopenia) ☐ no (if normal or osteoporosis)