BAY AREA OBSTETRICS & GYNECOLOGY, P.A.

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Diplomates of The American Board of Obstetrics and Gynecology

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

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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?

_____

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

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

_____

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 more than three (3) alcoholic drinks a day? Yes or No

27) Do you smoke? Yes or No

28) Do you drink coffee? Yes or No

29) Have either of your parents had a fractured hip? Yes or No

30) Have you ever been diagnosed with Rheumatoid arthritis? Yes or No

Patient Signature: _____ Date: _____

Technologist Signature: _____ Date: _____