

**AUSTIN RADIOLOGICAL ASSOCIATION
BONE DENSITY PATIENT SCREENING QUESTIONNAIRE**

Date: _____

Name: _____ Sex: _____ Date of Birth: ____/____/____

Y / N Have you had barium or IV contrast for any X-ray, CT, or Nuclear Medicine exams in the past month? If yes, when _____

Y / N Hip or Spine surgery? Left or right hip? Cervical, dorsal/thoracic, or lumbar spine? (circle appropriate answer)

Y / N Previous Bone Density exam? (most recent only)
when: _____ where: _____

Please circle one that is most appropriate: Asian Black Hispanic White
This is needed for the correct bone density analysis.

Current Weight: _____lbs Height: _____ft _____in

Please name, if any, osteoporosis medications you are currently taking. (such as Actonel, Boniva, Evista, Fosamax, Reclast.....) _____

Y / N Calcium supplement

Y / N ***Have you had any fractures during your adult life that occurred spontaneously, or a fracture from trauma, which in a healthy individual, would not have resulted in a fracture?***

Y / N Has either a parent or sibling been diagnosed with osteoporosis?

Y / N ***Has either your mother or father had a fractured hip?***

Y / N ***Do you currently smoke?***

Y / N ***Do you drink 3 or more alcoholic drinks daily?***

Y / N ***Do you take an oral steroid medication, or have you in the past, for more than 3 months at a time? (i.e. Prednisone)***

Y / N Do you have a thyroid condition requiring medication?

Y / N Do you take seizure medication?

Y / N Have you ever had any type of cancer, with chemotherapy or radiation treatments?
If yes, what type _____

Do you have any of the following medical conditions? Please check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> <i>Rheumatoid arthritis</i> | <input type="checkbox"/> <i>Type 1 diabetes (insulin dependent)*</i> |
| <input type="checkbox"/> <i>Adult osteogenesis imperfecta *</i> | <input type="checkbox"/> <i>Chronic liver disease *</i> |
| <input type="checkbox"/> <i>Malabsorption syndrome*</i> | <input type="checkbox"/> <i>Hypogonadism *</i> |
| <input type="checkbox"/> <i>Chronic malnutrition *</i> | <input type="checkbox"/> Anorexia or Bulimia |
| <input type="checkbox"/> <i>Untreated long-standing hyperthyroidism *</i> | |

Women:

Y / N Amenorrhea? (menstrual cycle stopped, not associated with menopause, pregnancy, or nursing)

Y / N Hot flashes?

Y / N ***Have you gone through menopause? If yes, were you less than 45 years old _____****

Y / N Do you take any type of estrogen or natural hormones? Name _____

Men:

Y / N Low testosterone?