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 which did not result from significant trauma (e.g. auto accident)?***
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 *Have you ever taken an oral steroid medication?*
Y / N ***If yes, for an oral steroid, did you ever take it for more than 3 months at a time?***
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.)

- □ ***Rheumatoid arthritis***
- □ ***Adult osteogenesis imperfecta ****
- □ ***Malabsorption syndrome ****
- □ ***Chronic malnutrition ****
- □ ***<u>Untreated</u> long-standing hyperthyroidism ****
- □ *Hyperparathyroidism*
- □ ***Type 1 diabetes (insulin dependent) ****
- □ ***Chronic liver disease ****
- □ ***Hypogonadism ****
- □ Anorexia or Bulimia

Women:

Y / N Amenorrhea? (menstrual cycle stopped, not associated with menopause, pregnancy, or nursing)
Y / N Hot flashes?
Y / N Do you use any type of estrogen or hormone therapy?
Age at menopause _____******

Men:

Y / N Low testosterone?