

AUSTIN RADIOLOGICAL ASSOCIATION BONE DENSITY PATIENT SCREENING QUESTIONNAIRE

Name: _____ Sex: _____ Date of Birth: _____ Date: _____

Have you had barium or IV contrast for any X-ray, CT, or Nuclear Medicine exams in the past month? YES NO

If yes, when _____

Hip or Spine surgery? Left or right hip? Cervical, dorsal/thoracic, or lumbar spine? YES NO
(check appropriate answer)

Previous Bone Density exam? (most recent only)

When: _____ Where: _____

Please check 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.....)

- Yes No Calcium supplement
- Yes No **Have you had any fractures during your adult life which did not result from significant trauma (e.g. auto accident)?**
- Yes No Has either a parent or sibling been diagnosed with osteoporosis?
- Yes No **Has either your mother or father had a fractured hip?**
- Yes No **Do you currently smoke?**
- Yes No **Do you drink 3 or more alcoholic drinks daily?**
- Yes No Have you ever taken an oral steroid medication?
- Yes No **If yes, for an oral steroid, did you ever take it for more than 3 months at a time?**
- Yes No Do you have a thyroid condition requiring medication?
- Yes No Do you take seizure medication?
- Yes No 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.)

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

Women:

- Yes No Amenorrhea? (menstrual cycle stopped, not associated with menopause, pregnancy, or nursing)
- Yes No Hot flashes?
- Yes No Do you use any type of estrogen or hormone therapy?

Age at menopause? _____

Men:

- Yes No Low testosterone?