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.)*

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

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?