

Inter Island Medical Center

550 Spring Street
Friday Harbor, WA 98250
(360) 378-2141

BONE DENSITOMETRY QUESTIONNAIRE

Please return this form to reception desk when it is completed

Name: _____ Date: _____

ID#: _____ Referring Physician _____

Weight: _____ Height: _____ Gender: M F Date of birth: _____

Are you RIGHT or LEFT-handed? _____ Race/Ethnicity: _____

For what reason did your doctor order this test? _____

Is this your first bone density test? _____ Yes ___ No

Have you had menopause? ___ Yes ___ No If yes, was it before age 40? ___ Yes ___ No

Have you had back surgery? ___ Yes ___ No

Have you had Hip surgery? ___ Yes ___ No LEFT or RIGHT?

Have you had wrist surgery? ___ Yes ___ No LEFT or RIGHT?

Have you EVER taken any of the following medications: ___ Fosamax ___ Evista
___ Actonel ___ Estrogen ___ Forteo ___ Calcium ___ Miacalcin ___ Boniva
___ Corticosteroids (Prednisone, etc) ___ Other /specify: _____

Have you EVER had any of the following medical conditions?

___ Hyperparathyroidism ___ Hyperthyroidism ___ Asthma or Emphysema
___ Seizures ___ Hysterectomy ___ Cancer ___ Anorexia or Bulimia ___ Arthritis
___ Inflammatory bowel disease ___ Bone disorder (such as rickets or osteomalacia)

QUESTION	YES	NO	SPECIFICS
Do you have a family history of osteoporosis?			
Do you have a diagnosis of osteoporosis?			
Do you have a diagnosis of osteopenia?			
Are you being treated for osteoporosis?			
Have you ever fractured a bone? Which bones & when?			
Do you smoke?			