UNION GENERAL HOSPITAL

BLAIRSVILLE, GA 30512

RADIOLOGY DEPARTMENT-
BONE DENSITOMETRY PATIENT QUESTIONNAIRE

Patient Name: _____ **DOB:** _____

Date: _____ **Height:** _____ **Weight:** _____ **Sex: (circle) M F**

Have you had this study done before? Yes No Where? _____ **When?** _____

MENOPAUSE (Questions for female patients only)

(Please circle if applicable)

Are you postmenopausal (Have you stopped having a period)?	**Yes**	**No**	
Have you had a hysterectomy?	**Yes**	**No**	**If "yes", how old were you?** _____
Did you have both of your ovaries removed?	**Yes**	**No**	
Is there a chance you could be pregnant?	**Yes**	**No**	

MEDICAL HISTORY

(Please circle if applicable)

Arthritis	**Yes**	**No**	**Epilepsy**	**Yes**	**No**	**MS**	**Yes**	**No**
Asthma	**Yes**	**No**	**Hyperparathyroidism**	**Yes**	**No**	**Organ Transplant**	**Yes**	**No**
Cancer	**Yes**	**No**	**Kidney Disease**	**Yes**	**No**	**Parkinson Disease**	**Yes**	**No**
Celiac Disease	**Yes**	**No**	**Liver Disease**	**Yes**	**No**	**Paget's Disease**	**Yes**	**No**
Crohn's Disease	**Yes**	**No**	**Loss of Height**	**Yes**	**No**	**Scoliosis**	**Yes**	**No**
Diabetes	**Yes**	**No**	**Lupus**	**Yes**	**No**	**Thyroid Problems**	**Yes**	**No**
Eating Disorder	**Yes**	**No**	**Malabsorption**	**Yes**	**No**	**Rheumatoid Arthritis**	**Yes**	**No**

Do you take medication for stomach or intestinal disorder? Yes No
Do you use tobacco? Yes No Have you ever smoked for 5 years in the past? Yes No
Do you drink 3 or more alcoholic drinks per day? Yes No
Do you exercise 2 or more days a week? Yes No
Do you take Steroids regularly? Yes No
Have you had any broken bones in the last 5 years? Yes No
Have you had prior surgery to your: (Circle all that apply) Right Hip Left Hip Lumbar Spine Right Wrist Left Wrist

OSTEOPOROSIS

Do you have a Family History of Osteoporosis? Yes No
Have you been diagnosed with Osteoporosis? Yes No Osteopenia? Yes No
Are you being medically treated for Osteoporosis or Osteopenia (other than Calcium)? Yes No
If "YES", which medication(s) are you taking and for how long? (Please circle applicable)

- ❑ **Fosamax** _____
- ❑ **Boniva** _____
- ❑ **Prolia** _____
- ❑ **Actonel** _____
- ❑ **Forteo** _____
- ❑ **Reclast** _____
- ❑ **Miacalcin** _____
- ❑ **Evista** _____
- ❑ **Estrogen or Hormone Replacement** _____

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PATIENT STICKER