Family Practice Associates
a professional corporation

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BONE DENSITOMETRY QUESTIONNAIRE

PHYSICIAN: ___ DR. TERRANCE SIMON
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___ DR. WAYNE LUTZKE

PATIENT NAME: _____ DOB: _____
(please print) (first) (middle initial) (last)

RACE: _____Caucasian _____ Hispanic ___ Asian _____ African-American

HEIGHT _____ WEIGHT _____

MENOPAUSAL AGE:_____ HYSTERECTOMY_____

HAVE YOU EVER HAD A BONE DENSITY TEST HERE IN THIS OFFICE?
_____YES _____ NO

IF NOT, WHERE DID YOU HAVE YOUR LAST ONE? _____

IS THERE ANY CHANCE OF PREGNANCY? _____ YES _____ NO

HAVE YOU EVER HAD BACK SURGERY? _____

HIP SURGERY? ___RIGHT ___LEFT

DO YOU HAVE A FAMILY HISTORY OF OSTEOPOROSIS? _____

IF YES WHO?_____

DO YOU SMOKE? _____DRINK ALCOHOL?_____

EXERCISE? _____WEIGHT BEARING? _____

HAVE YOU HAD ANY FRACTURES? _____ *(if yes, what was broken?)*

HAVE YOU EVER TAKEN HORMONE REPLACEMENT THERAPY? _____

HAVE YOU EVER HAD CHEMOTHERAPY?_____

HAVE YOU EVER BEEN ON SEIZURE MEDICATION?_____

HAVE YOU EVER TAKEN STEROID MEDICATION? _____
(prednisone, cortisone, etc)

DO YOU HAVE A HISTORY OF LOW TESTOSTERONE LEVELS?_____

DO YOU TAKE CALCIUM SUPPLEMENTS DAILY? _____

HAVE YOU HAD) ANY PROCEDURES IN THE LAST 7 DAYS THAT CONTAINED THE FOLLOWING SUBSTANCES WHICH COULD INTERFERE WITH THE TEST?

_____IODINE _____BARIUM _____ ISOTOPE
(nuclear medicine study)

PATIENT SIGNATURE:_____ DATE:_____

TECHNOLOGIST SIGNATURE:_____