

Your physician has ordered a Bone Density Scan. This scan is done here in the office. To prepare for your bone density scan please do the following:

* Please do not schedule any test(s) involving x-ray dye or nuclear medicine tests at least 3 days prior to your bone density scan.
* Avoid taking calcium supplements 24 hours prior to your scan.
* On the day of your appointment, eat normally and take your usual medications.
* Please wear loose-fitting, comfortable clothes without zipper, buttons or metal of any kind.
* Please report to the front desk 10-15 minutes before your appointment and bring your completed questionnaire with you.

**Please be advised, if it has been less than two years from your last bone density study there is a chance this study may not be covered by your insurance.**

If you have any questions or you need to change or schedule your appointment please call JoAnne Watach @ 804-288-7901 ext. 361

**BONE DENSITY QUESTIONNAIRE**

**Please print this questionnaire, complete all pages and bring it with you on the day of your scan.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Choose one: \_\_ Female \_\_ Male Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has the patient had a previous bone density study? \_\_Yes \_\_ No

When:\_\_\_\_\_\_\_\_\_\_ Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Family history of Osteoporosis? \_\_Yes \_\_ No
2. Has patient had Bilateral Oophorectomy? (Ovaries removed) \_\_Yes\_\_ No Year: \_\_\_\_\_
3. Age at onset of menopause (non-surgical) \_\_\_\_\_\_\_
4. Have you ever taken hormone replacement (HRT) for any reason? \_\_ Yes \_\_ No
5. History of fracture? \_\_\_\_ \_\_ hip \_\_ vertebrae \_\_ wrist \_\_ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. History of steroid use? \_\_ prednisone \_\_ other oral or inhaled steroids

What reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever been on therapy for Osteoporosis? \_\_\_ Yes \_\_\_ No

If yes, date started: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Fosamax \_\_ Actonel \_\_ Miacalcin \_\_ Evista \_\_ Didronel

\_\_ Hormone replacement therapy

\_\_ Other :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. History of the following:

Thyrotoxicosis (overactive thyroid) \_\_ Yes \_\_ No

Hypoparathyroidism (underactive parathyroid ) \_\_ Yes \_\_ No

Malabsorption Syndrome (Inflammatory Bowel Disease) \_\_ Yes \_\_ No

Turner's Syndrome \_\_ Yes \_\_ No

Renal Failure (Kidney disease) \_\_ Yes \_\_ No

Post Gastrectomy Syndrome (Gastric bypass surgery) \_\_ Yes \_\_ No

Rheumatoid Arthritis \_\_ Yes \_\_ No

Cushings Syndrome \_\_ Yes \_\_ No

1. Evidence of the following:

Patient is slender and small boned \_\_ Yes \_\_ No

Poor intake of dairy products due to milk allergy/other causes \_\_ Yes \_\_ No

Excessive dental caries and/or significant peridontal disease \_\_ Yes \_\_ No

Patient leads a sedentary life / exercises less than twice a week \_\_ Yes \_\_ No

Loss of height \_\_ Yes \_\_ No

1. Evidence of the following

History of: smoking \_\_ Yes\_\_ No

regular alcohol consumption \_\_ Yes\_\_ No

excessive use of caffeinated \_\_ Yes\_\_ No

beverages or soft drinks \_\_ Yes\_\_ No

History of breast feeding children \_\_ Yes \_\_ No

Patient has been pregnant \_\_ Yes \_\_ No

Ever used birth control pills \_\_ Yes \_\_ No

Long term antacid administration \_\_ Yes \_\_ No

Diabetes Mellitus \_\_ Yes \_\_ No