XRAY ASSOCIATES
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Osteoporosis Questionnaire

Patient Name:_____

Weight:_____.

Height:_____.

Patient History:

1. Have you had a previous bone density exam here? Have you had a previous bone density at another location?	❑ Yes ❑ No ❑ Yes ❑ No
2. Have you had any surgery on your back? Have you had any surgery on your hips?	❑ Yes ❑ No ❑ Yes ❑ No
3. Have you had a nuclear medicine exam or x-ray exam with contrast material in the last 5 days?	❑ Yes ❑ No
4. Do you smoke?	❑ Yes ❑ No
5, Do you take calcium supplements?	❑ Yes ❑ No
6. Are you taking, or have you ever taken, Fosamax or Didrocal or Evista or Actonel?	❑ Yes ❑ No
7. Have you been on Prednisone or steroid for a long period? If yes, for how long? _____. If yes, what was your dosage? _____.	❑ Yes ❑ No
8. Do you take medication for your thyroid?	❑ Yes ❑ No
9. Has anyone in your family had osteoporosis? If yes, who:	❑ Yes ❑ No

Female Patients Only:

10. Are you pregnant?	❑ Yes ❑ No
11. Are you on hormone replacement therapy? If yes, what is your dosage?	❑ Yes ❑ No
12. Are you post-menopausal (finished menses)?	❑ Yes ❑ No
13. Have you had a hysterectomy? A) Ovaries & Uterus B) Uterus only If yes, when? _____.	❑ Yes ❑ No ❑ Yes ❑ No