Bone Densitometry Program

Mount Sinai Radiology Associates

Patient History Questionnaire

Date: _____ Initial visit or follow-up? (Please circle one)

Name: _____

Date of birth: _____ Age: _____ Female or Male (please circle one)

Ethnic (please circle one): ☐ White ☐ Black ☐ Hispanic ☐ Asian Height: _____ Weight: _____

Referring Doctor: _____

Please circle each answer that applies:

Could you be pregnant? ☐ Yes ☐ No

Have you fractured or had surgery on you:

Spine?	☐ Yes	☐ No
Hip?	☐ Yes	☐ No
Forearm?	☐ Yes	☐ No

Have you had X-ray or radioactive tests in the last two weeks? ☐ Yes ☐ No

If yes, please explain: _____

_____

Have you reached menopause? ☐ Yes ☐ No Age at menopause: _____

Have you had both ovaries surgically removed ☐ Yes ☐ No Age at surgery: _____

Please check all that applies:

Do you have any of the following?

- ☐ Absence of menstruation before menopause
- ☐ Hyperthyroidism
- ☐ Hyperparathyroidism
- ☐ Testosterone deficiency
- ☐ Cushing's syndrome

Are you taking medication for osteoporosis?

- ☐ Estrogen Date began: _____
- ☐ Fosamax Date began: _____
- ☐ Evista Date began: _____
- ☐ Miacalcin Date began: _____
- ☐ Actonel Date began: _____
- ☐ Other Date began: _____
- ☐ Calcium
- ☐ Vitamin D

Treatment with:

- ☐ Steroids (prednisone, etc)?
- ☐ Seizure medication?
- ☐ Thyroid hormone?

Intestinal disease, malabsorption

- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Gaucher's Disease