MEDFORD RADIOLOGY GROUP

Bone Density Patient Questionnaire

Name:		**Height:**	**Weight:**
Birth Date:	**Age:**	**Gender:** Female Male	
Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other:_____			
• **Have you ever had a bone density test?** YES NO		**If YES, When and Where:**	
• **Have you had a barium x-ray or CT scan in the last 2 weeks?**			YES NO
• **Have you had a nuclear medicine scan or injection of dye in the last week?**			YES NO
• **Do you have a history of hyperparathyroidism or a high calcium level in your blood?**			YES NO
• **Have you ever broken a bone?** YES NO		**Which bone:** _____ **At what age:** _____	
• **Have you ever had surgery on your spine, hips, or wrist?** YES NO		**If YES, please describe:**	
Do you smoke?	→ YES NO		
Do you consume alcohol daily?	→ YES NO		
Have you had breast cancer?	→ YES NO		
Have you had prostate cancer?	→ YES NO		
Have you gone through menopause?	→ YES NO	**If YES, at what age?**	
Have you had a hysterectomy?	→ YES NO	**Complete or Partial?** _____	
Please list any pertinent medications:			