THE
BREAST CENTER
of GREENSBORO IMAGING
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Bone Density Screening Questionnaire

Name (print): _____ Date: _____

Is there a chance that you are pregnant? Yes No

Have you had a barium X-ray in the last 2 weeks? Yes No

Have you had a nuclear medicine scan or injection of an X-ray dye in the last week? Yes No

Your age: _____ Your sex (circle): Female Male

Have you ever had a bone density test? Yes No

Where? _____

Your tallest height (late teens or young adult): _____

Your ethnicity (circle): Caucasian (white) Black Asian Hispanic Other

Have you ever broken a bone from a simple fall or bump? Yes No

Did either of your parents have a broken hip? Yes No

Do you smoke? Yes No

Have you taken steroids (glucocorticoids) in the past? Yes No

For how long? _____

Do you have Rheumatoid Arthritis? Yes No

Do you have any ongoing medical problems? Yes No

Please list _____

Do you drink alcohol? Yes No

Do you have (circle): 0 - 2 drinks/day 3 or more drinks/day

Have you had hyperparathyroidism or a high calcium level in your blood? Yes No

Have you had surgery of the spine, hips, legs or arms? Yes No

If yes, which bone, which side? _____

Do you take calcium? Yes No How much? _____

Do you take vitamin D? Yes No How much? _____

For women only:

When was your last period? _____

Have you had a hysterectomy? _____

Have you had your ovaries removed? _____

Are you currently taking or have you previously taken any of the following medications?

Prednisone (cortisone)	Yes	Currently / in the past? For how long? _____
Medication for seizures or epilepsy	Yes	Currently / in the past? For how long? _____
Medication for prostate cancer	Yes	Currently / in the past? For how long? _____
Medication to prevent transplant rejection	Yes	Currently / in the past? For how long? _____
Chemotherapy for cancer	Yes	Currently / in the past? For how long? _____
Name of medicine: _____		
Hormone therapy for cancer	Yes	Currently / in the past? For how long? _____
Name of medicine: _____		

Hormone replacement therapy (Estrogen)	Yes	Currently / in the past? For how long? _____
Raloxifene (Evista)	Yes	Currently / in the past? For how long? _____
Testosterone	Yes	Currently / in the past? For how long? _____

Sodium fluoride (Fluotic)	Yes	Currently / in the past? For how long? _____
Teriparatide (Forteo, PTH)	Yes	Currently / in the past? For how long? _____
Calcitonin (Miacalcin or Fortical)	Yes	Currently / in the past? For how long? _____
Etidronate (Didronel/Didrocal)	Yes	Currently / in the past? For how long? _____
Alendronate (Fosamax)	Yes	Currently / in the past? For how long? _____
Risedronate (Actonel)	Yes	Currently / in the past? For how long? _____
Intravenous pamidronate (Aredia)	Yes	Currently / in the past? For how long? _____
Clodronate (Bonefos, Ostac)	Yes	Currently / in the past? For how long? _____
Ibandronate (Boniva)	Yes	Currently / in the past? For how long? _____
Zoledronic acid (Zometa, Reclast)	Yes	Currently / in the past? For how long? _____
Other bone building therapy _____	Yes	Currently / in the past? For how long? _____