**St. Mary Medical Center**
**BONE DENSITY QUESTIONNAIRE**

**Patient Name (print)_________________________________ Date _______________**

**Date of Birth __________________________**

| **Answer the questions by checking the appropriate response (yes, no, don't know) to the right. If your answer is "yes", enter additional information in box at left.** | **Yes** | **No** | **Don't Know** |
|---|---|---|---|
| ***Gynecologic History (women only)*** | | | |
| ▪ Are you pregnant? | | | |
| ▪ Date of Last Menstrual Period ________________ | | | |
| ▪ Are (were) your periods regular between 18 and 40 years? | | | |
| ▪ Did you ever have intervals with few or no bleeding cycles, other than during pregnancy?<br>Age Length of Time | | | |
| ▪ Have you had a hysterectomy? If "yes" which year? | | | |
| ▪ Have you entered menopause? If "yes" which year? | | | |
| ***Medications*** | | | |
| ▪ Are you now taking hormone replacement pills or using patches? | | | |
| ▪ Do you take cortisone, prednisone, or other steroids for treatment of asthma, arthritis, or cancer? | | | |
| ▪ Do you ever take sleeping pills? If "yes" how often? | | | |
| ▪ Do you take Calcium? | | | |
| ▪ Do you take Vitamin D? | | | |
| ▪ Do you take thyroid medication? | | | |
| ▪ Are you on any other medications? | | | |
| ***Lifestyle*** | | | |
| ▪ Do you smoke cigarettes? Packs/Day | | | |
| ▪ Do you drink alcoholic beverages? Drinks/Day | | | |
| ▪ Do you exercise regularly? Amount/Day | | | |
| ***Fractures/Falls*** | | | |
| ▪ Have you ever broken any bones?<br>Year__________ Site ________________________________<br>How? | | | |
| ***History of Osteoporosis and Back Pain*** | | | |
| ▪ Does anyone in your immediate family have osteoporosis?<br>Mother ________ Father _________<br>Sister(s) ________ Brother(s) _________ | | | |
| ▪ Do you ever have back pain?<br>Circle choice: Mild or Severe<br>Dull or Sharp<br>Intermittent or Constant | | | |