

SCHAFFER, SCHONHOLZ & DROSSMAN, LLP

New York, New York 10022

PATIENT QUESTIONNAIRE for BONE DENSITY STUDY

PLEASE PRINT CLEARLY:

Name: _____ Date: _____

In order to help us to accurately evaluate this exam, please complete this short questionnaire.

1. Date of birth: _____
2. When was your last period? _____
3. Have you had this test before? Yes No
If so, where: _____
4. Are you currently taking any medication for osteoporosis? Yes No
If yes, which: _____
5. Have you ever fractured your spine or hip? Yes No
6. Have you ever had any surgery of your spine or hip? Yes No
7. Have you had any recent x-rays or CAT scans in which you had
to drink barium? Yes No
8. Do you consume more than 3 alcoholic beverages per day? Yes No
9. Did either or both of your parents have a hip fracture? Yes No
10. Do you have a history of long term steroid use? Yes No
11. Have you had a fracture as an adult? Yes No
12. Do you have rheumatoid arthritis? Yes No
13. Do you currently smoke? Yes No