SCHONHOLZ and DROSSMAN, LLP

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. If applicable, when was your last menstrual period? ______________
3. Have you had this test before? Yes ❒ No ❒

   If so, where: ______________________________

4. Are you 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 ❒
14. Did you take a calcium pill today? Yes ❒ No ❒