UNIVERSITY OF WASHINGTON MEDICAL CENTER RADIOLOGY
Bone Density Questionnaire

Name ______________________________ **DOB** ___/___/____ **Doctor** ____________________

Tallest Height ___'___" **Current Height** ___'___" **Current Weight** _____**lbs.** **Ethnic Group** ____________

Chronic conditions/illnesses: *please check all that apply*

☐ Osteoporosis	☐ Cushing's Disease	☐ Intestinal Malabsorption
☐ Hyperactive Thyroidism	☐ Addison's Disease	☐ Calcium Malabsorption
☐ Hyper*para*thyroidism	☐ Anorexia or Bulimia	☐ Osteomalacia
☐ Paget's Disease	☐ Organ Transplant	☐ Vitamin D Deficiency
☐ Grave's Disease	☐ Crohn's Disease	☐ Chronic Kidney Dysfunction
☐ Hashimoto's Disease	☐ Ulcerative Colitis	☐ Inflammatory Bowel Disease

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Female questions: *please check all that apply*

- ☐ I have gone through menopause. *If true, at what age?* ________________
- ☐ My periods are somewhat irregular *and* I may be in perimenopause.
- ☐ My doctor thinks I may need estrogen supplements.
- ☐ I have had breast cancer.
- ☐ I have a family history of breast cancer.
- ☐ I had a hysterectomy. *If true, at what age?* ______________
- ☐ I had **one / both** *(circle 1)* of my ovaries surgically removed. *If true, at what age?* ____________
- ☐ Previous to menopause, my periods were often irregular.

What medications have you taken? *please check all that apply*

- ☐ I have taken STEROIDS *(PREDNISONE)*.
- ☐ I have taken THYROID PILLS.
- ☐ I have taken DILANTIN or PHENOBARBITAL.
- ☐ I have taken HEPARIN.
- ☐ I have taken FOSAMAX.
- ☐ I have taken MIACALCIN or CALIMAR.
- ☐ I have taken EVISTA.
- ☐ I have taken ESTROGEN *(Premarin, Estrogen Patch, etc.)*

PLEASE TURN THE PAPER OVER AND COMPLETE THE BACKSIDE

PT.NO

NAME

DOB

UW Medicine
Harborview Medical Center – UW Medical Center
Northwest Hospital & Medical Center – University of Washington Physicians
Seattle, Washington

BONE DENSITY QUESTIONNAIRE

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Habits that effect bone: *please check all that apply*

- ☐ I take calcium supplements at least 3 – 4 times per week. If so, what is the dosage _______
- ☐ I eat calcium rich foods every day.
- ☐ I am unable to tolerate milk products.
- ☐ I seldom consume milk products.

Per week,
I exercise: (circle one) 0 / week 1 - 2 / week 3 – 4 / week 5 - 6 / week 7 / week

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Risk Factors: *please check all that apply*

- ☐ I have lost more than 1 inch in height.
- ☐ I had some bone loss diagnosed previously from an x-ray.
- ☐ I have developed a curved upper back ("Dowager's Hump")
- ☐ I am disabled and immobilized.
- ☐ I have fallen more than 1 time this year.
- ☐ I have had a broken bone(s) in the last 5 years.

If true,
Which bones? ____

How did it happen? ____

FRAX: *please check all that apply*

- ☐ On average, I drink **3** or more alcoholic beverage per day.
  (12 oz Beer, 5 oz Wine, 1.5 oz Spirits)
- ☐ My mother or father broke or fractured their hip.
- ☐ I have taken Prednisone, Cortisone, or a glucocorticosteroid for longer than 3 months.
- ☐ As an adult, I have broken, fractured, or cracked a bone.
  (do not count bones in the head, neck, hands, feet or knee cap, or fractures from a car accident)
- ☐ I have a serious medical problem with my liver, kidneys, intestines, lungs, blood, hormones or muscles, or have diabetes, seizures, or strokes.
- ☐ My doctor has told me that I have rheumatoid disease.
- ☐ I currently smoke cigarettes.

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE

PATIENT SIGNATURE	PRINT NAME	DATE	TIME

PT.NO

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