Family Medicine Associates
CLEBURNE • JOSHUA
A member of I-35 Capital Physicians Group

Bone Density Questionnaire

Date:_____

Name:_____Gender: M F

Date of Birth:_____ Ethnicity: (Circle one) Caucasian African-American Hispanic Asian Other

Height:_____ Weight:_____Eye Color:_____Hair Color:_____

Build: (Circle One) Small Medium Large

Referring Doctor:_____

Social Security #:_____ Is there any possibility you may be pregnant? Y N

Have you had this examination before? Y N

If yes, what facility?_____

Are you (circle one) right-handed or left-handed

Have you had hip replacement surgery? Y N
If yes, which hip? Right Left Both

Have you had any surgeries on your lower back?

If yes, what procedures?_____

Do you have a known curvature (scoliosis) of spine? Y N

Have you had any examinations in the past seven (7) days in which you were injected with or ingested a contrast material, i.e. barium? Y N If so, what exam?_____

Do you have a family history of osteoporosis? Y N

Do you take any medications? Y N
If yes, please list:_____

Do you take calcium supplements? Y N

Do you or have you taken corticosteroids? Y N

Are you post-menopausal? Y N

At what age did menopause occur?_____

Have you had a hysterectomy? Y N

Are you on hormone replacement therapy? Y N
If yes, number of years on estrogen:_____

Do you have any perceived height loss? Y N

Do you exercise regularly? Y N

Do you smoke? Y N

Do you drink alcohol? Y N

Do you drink coffee? Y N

Patient signature:_____ Date:_____

Technologist signature:_____ Date:_____