Bone Density Scan Questionnaire

Date: _______________________

Patient Name: ______________________________  Age: __________________

Previous bone density scan: Yes _____ No _____  When/where: ___________

Are you pregnant?  Yes _____  No _____  LMP _______________________

Please check one of the following:

Pre-menopausal_____  Peri-menopausal_____  Post-menopausal_____  

Have you been diagnosed with osteoporosis?  Yes_____  No_____  

Are you taking long term steroid medications or other medications that cause osteoporosis?  (please specify):  ________________________________

Do you have a history of any of the following?  (please check all that apply):

Hyperparathyroidism ___  Cushing’s Syndrome___  Premature Menopause ___  
Turner’s Syndrome, XO Syndrome, Gonadal dysgenesis___
Ovarian Failure: (due to radiation or chemotherapy) ____  (cause unknown)____

Have you had any x-ray studies or nuclear medicine test done in the last month? ____  If yes, please specify. __________________________________________

Do you have any history of fractured bones in the hip, neck, back, sacrum/coccyx, or forearm? _____  If yes, please specify ________________________________

Have you had hip replacement? _____  If yes, which hip? __________________

Are you right or left handed? __________________________________________

Do you know why you are having this test? If yes, please specify
_____________________________________________________________________

Technologist: ______________________

GCM-BONE