Print Form

THE AUSTIN DIAGNOSTIC CLINIC
12221 N MOPAC EXPWY
AUSTIN, TX 78758-2483
PH: 512/ 901-4022
FAX: 512/ 901-3932

Name:_____

Date: _____

Ethnicity: _____

Bone Densitometry Questionnaire Form

Please complete **the front page** of this questionnaire and bring it to your appointment.

Instructions for your appointment:

1. Do not take any calcium or over the counter vitamins 48 hours prior to the exam.
2. Wear no zippers or metal on your clothing.

RISK FACTORS FOR OSTEOPOROSIS: Please check all that apply

- ☐ Personal history of adult bone fracture
  If yes, Please indicate location of fracture_____
- ☐ Family history of Osteoporosis
  If yes, Please indicate relationship _____
- ☐ Parental history of hip fracture

INDICATIONS: Please check all that apply

- ☐ Low Calcium intake(fewer than 3-4 servings daily of dairy)
- ☐ Low Vitamin D Intake(Less than 400 IU per day)
- ☐ Low Body weight(<124 lbs)
- ☐ Current Smoker
- ☐ Past Smoker
- ☐ Alcohol intake >3 drinks per day
- ☐ Caffeinated Beverages (coke, coffee,tea)
- ☐ Renal Failure/Dialysis
- ☐ Immunosuppressant Medication/Organ Transplant
- ☐ Anti-seizure Medication _____no. of years
- ☐ History of eating disorder
- ☐ Amenorrhea (no menstrual cycle more than 6 mo prior to menopause)
- ☐ Rheumatoid Arthritis/Osteoarthritis
- ☐ No. of years Thyroid hormone use
- ☐ Chemotherapy or radiation treatment
- ☐ Long-term steroid treatment (Prednisone)
- ☐ Inadequate physical activity
- ☐ Recurrent Falls (due to weakness/medical conditions)
- ☐ Testosterone Deficiency
- ☐ Postmenopausal at age ☐
- ☐ Hysterectomy ☐ Partial ☐ Full
- ☐ PeriMenopausal
- ☐ Date of last menstrual cycle _____

TREATMENTS: Please indicate dates of use

Start date	Stop date		Start Date	Stop Date	
_____	_____	Actonel (Risedronate)	_____	_____	Fosamax (Alendronate)
_____	_____	Didronel	_____	_____	Estrogen (NRT)
_____	_____	Nasal Micalein	_____	_____	Tamoxifen / Arimidex
_____	_____	Evista	_____	_____	Testosterone
_____	_____	Fortco	_____	_____	Coumadin / Farfarin
_____	_____	Boniva / Reclast	_____	_____	Rocaltrol
_____	_____	Casodex	_____	_____	Lupron

FOR OFFICE USE ONLY, (*PLEASE DO NOT FILL IN THE SECTION BELOW*):

	Previous	Current	Loss/Gain
Height	_____	_____	_____
Weight	_____	_____	_____

	Calcium	Vitamin D
Dietary	_____	_____
Supplements	_____	_____
Total	_____	_____