WCH
WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

BONE MINERAL DENSITOMETRY QUESTIONNAIRE

Office Use
Appt Date: DD/MM/YYYY Time: _____
Copies to Osteoporosis Program: ☐Yes ☐ No

Referring physician:_____
Name (please print) Phone #/ address Fax #

Copy to other physician:_____
Name (please print) Phone #/address Fax #

Have you had an X-ray with barium in the last 2 weeks? ☐ **Yes** ☐ **No**

Have you had a Nuclear Medicine scan, MRI, CT scan or X-ray with injection of a dye in the last week? ☐ **Yes** ☐ **No**

If you answered YES to any of the above questions please tell the secretary before your test

Please answer the following questions. If you need assistance in completing this questionnaire, the Technologist can help you at the time of your test.

Have you had a previous Bone Mineral Density (BMD) test done? ☐ **No** ☐**Yes** ▸ **When?** DD/MM/YYYY
Where? ☐ **WCH** ☐ **Other**

Spinal &/or hip surgery? ☐ **No** ☐**Yes** ▸ please specify: _____

Low trauma fracture after age 40? ☐ **No** ☐ **Yes** ▸ ☐ **Hip** ☐ **Wrist** ☐ **Spine** ☐ **Rib**
☐ **Other bones,** specify: _____

Are you currently taking oral steroids (not inhaled)? ☐ **Yes** ☐ **No**

For those assigned female at birth:
Are you still menstruating? ☐ **Yes** ▸ Is there a possibility that you are pregnant ☐ **Yes** ☐ **No**
☐ **No** ▸ At what age did you go through menopause? _____

If you no longer have periods, was this the result of:
a) Trans hormone therapy ☐ **No** ☐ **Yes**
b) Natural menopause ☐ **No** ☐ **Yes**
c) Chemotherapy ☐ **No** ☐ **Yes**
d) Hysterectomy ☐ **No** ☐ **Yes**→were the ovaries removed?☐ No ☐ 1Ovary ☐ Both ☐ Don't know

Did you have your first period after age 14? ☐ **No** ☐ **Yes** ▸ if Yes at what age_____

Has your mother or father ever broken their hip? ☐ **Yes** ☐ **No** ☐ **Don't know**

Do you currently smoke? ☐ **Yes** ☐ **No**

Do you drink *more than 3* alcoholic beverages a day? ☐ **Yes** ☐ **No**
(1 beverage = 10oz beer = 4oz wine = 1 oz hard liquor)

Office Use Technologist Notes:

Height:_____cm Change:_____ Weight:_____kg Change:_____

_____

_____

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Have you ever taken any of the following medication(s) for your bones?

	Never	Currently	Previously	Date Stopped
Fosamax / Actonel / Didrocal Alendronate/ Risedronate/ Etidronate)	☐	☐	☐	_____
Evista(Raloxifene)	☐	☐	☐	_____
FORTEO (PTH, Teriparatide)	☐	☐	☐	_____
IV Aclasta(Zoledronic Acid)/ IV Pamidronate	☐	☐	☐	_____
Prolia(Denosumab)	☐	☐	☐	_____
Other Osteoporosis Medications:_____	☐	☐	☐	_____

Have you ever taken any of the following hormones?

	Never	Currently	Previously	Date Stopped
Hormone Replacement Therapy: Estrogen (Oral/Patch)	☐	☐	☐	_____
Depo Provera injections for more than 1 year	☐	☐	☐	_____
Lupron	☐	☐	☐	_____
Testosterone	☐	☐	☐	_____

Have you ever taken any of the following medication(s)?

	Never	Currently	Previously	Date Stopped
Oral or IV Steroids (Prednisone) for ***at least 3 months***	☐	☐	☐	_____
Inhaled steroids **every** day for ***at least 1 year*** (not Ventolin)	☐	☐	☐	_____
Anti-seizure meds (Dilantin, Tegretol, Phenobarbitol) for ***at least 3 months***	☐	☐	☐	_____
Treatment of Breast Cancer: Tamoxifen	☐	☐	☐	_____
Treatment of Breast Cancer: Aromatase Inhibitors (Arimidex(Anastrozole), Femara(Letrozol), Aromasin(Exemestane))	☐	☐	☐	_____
Chemotherapy specify reason: _____	☐	☐	☐	_____
Hormone treatment for Prostate Cancer(androgen-deprivation)	☐	☐	☐	_____

Have you ever been diagnosed with the following medical conditions by a physician?

Please circle the answer either Yes (Y) or No (N):

Emphysema/COPD	**Y / N**	Inflammatory Arthritis (eg. Rheumatoid/ Psoriatic/Ankylosing Spondylitis)	**Y / N**
Asthma	**Y / N**		
Ulcerative Colitis	**Y / N**	Systemic Lupus Erythematosus	**Y / N**
Crohn's Disease	**Y / N**	Cancer, not including skin cancer	**Y / N**
Celiac Disease	**Y / N**	Specify: _____	
Kidney Failure	**Y / N**	Multiple Myeloma	**Y / N**
Overactive thyroid, now or in the past	**Y / N**	Bone Marrow Transplant	**Y / N**
Hyperparathyroidism	**Y / N**	Organ Transplant	**Y / N**
Eating Disorder (Anorexia Nervosa)	**Y / N**	Other long-standing medical problem Specify: _____	**Y / N**