Osteoporosis Screening Questionnaire

Atlantic General Hospital Women's Diagnostic Center

Name:_________________________________ **Date**:__________________

Referring Physician:_________________**Primary Physician:**__________________

Sex:_______________ **Date of Birth**:________________ **Age**:_________________

Weight:_______**Height**:______(feet)_______(inches**)** **Tallest Height**:_____________

Are you: Right Handed__________ or Left Handed___________

1. Have you had this test done previously through Atlantic General Hospital? YES NO

2. Is there a family history of Osteoporosis? YES NO

3. Have you had x-rays in the last week with contrast or dye? YES NO

4. Have your periods stopped? YES NO
   If so, when was your last period? ____

5. Have you had a hysterectomy? YES NO
   If so, at what age? ____

6. Have you ever had breast cancer? YES NO
   Did you have chemotherapy? YES NO
   Did you have Radiation? YES NO

7. Are you taking estrogen? YES NO
   If so, for how long? ____

8. Please list all your prescription and over the counter medications you are currently taking:

   ____

   ____

9. Have you had any spine or hip surgery? YES NO
If so, what did you have done? ______________________________

10. Have you broken or fractured any bones? YES NO
Please list: ______________________________

11. How much alcohol do you drink in an average week? ______________________________

12. Do you now or have you ever smoked? YES NO
How much? ______________________________

13. How much caffeine (sodas, coffee, tea and chocolate) do you consume in a day?
____

14. Have you ever taken long-term steroid medications such as prednisone, or cortisone? YES NO

15. Have you ever been diagnosed with thyroid disease? YES NO

16. Have you ever been diagnosed with parathyroid disease? YES NO

17. Do you exercise regularly? YES NO
What kind? ______________________________

How often? ______________________________

Technologist Comments:

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