



LPXNA002

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Please complete the following questions to the best of your ability. If you are unsure how to answer, leave the space blank and we will help with the answer when you are seen at this facility. All answers will be kept in strict confidence and treated as information in your medical records.

Name: _____

Street address: _____

City: _____ State: _____ Zip _____

Date of birth _____

Race: Afro-American__ Caucasian__ Native American_ Oriental__ Other__

Sex: Male__ Female:___

Have you fractured any bones during your adult life? _____

Is there a family history of osteoporosis? _____

Has either parent ever sustained a hip fracture? _____

Do you smoke more than 1/2 pack of cigarettes per day? _____

Have you smoked in the past? _____

How many servings of dairy products do you consume each day? _____

Do you take a calcium supplement daily? _____

Do you exercise three times per week? _____

Do you drink more than two alcoholic drinks per day? _____

Have you taken any of the following medications:
Steroids (Predisone, Cortisone, etc) _____

Thyroid medication: _____

Anticonvulsants (for seizures, epilepsy) _____

RAD BONE DENSITY QUESTIONNAIRE

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Have you had any of the following conditions:

Partial or complete paralysis _____
Hyperthyroidism (overactive thyroid) _____
Kidney disease _____
Rheumatoid arthritis _____
Other arthritis _____
Part of stomach removed _____
Intestinal or bowel disease _____

Height: _____ Inches: _____ Weight: _____

REMAINING QUESTIONS FOR FEMALES ONLY

Have you gone through menopause? _____
Did your menopause occur before age 45? _____
Do you have amenorrhea (never started periods or ended at a young age)? _____
Do you now take hormones (Premarin, estrogen, etc.) _____
Have you taken hormones (not including birth control pills) in the past? _____
Have you had any of the following side effects from hormones:
Breast soreness _____
Heavy periods or other bleeding _____
Headaches _____
Weight gain or fluid buildup _____
Other _____

How long have you taken or did you take hormones? _____
Have you had any of the following conditions:
Hysterectomy _____
Ovaries removed _____
Blood clots _____
If yes, were you on hormones at the time _____
Breast cancer _____
Family history of breast cancer _____
Cancer of the uterus _____

PRINT PATIENT NAME

PATIENT SIGNATURE

DATE

TIME

RAD BONE DENSITY QUESTIONNAIRE

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