Barnet Medical Plaza
680 Broadway, Suite 111 Paterson N.J. 07514
P: 973.977.6662 F: 973.341.1128
Towne Centre
3 Walter E. Foran Blvd., Suite 312 Flemington N.J. 08822
P: 908.284.2300 F: 908.442.7432

Bone Density Questionnaire

Patient Name: _____ **PID:** _____
Today's Date: _____/_____/_____ **Date of Birth:** _____/_____/_____
Sex: ☐ **Male** ☐ **Female**
Ethnic Origin: ☐ African-American ☐ White, Caucasian ☐ Hispanic ☐ Asian ☐ Other ☐
Previous Height: _____ **Current Height:** _____ **Current Weight:** _____

Gynecological History:
Date of last menstrual period: _____ Pregnant? _____
Menopause? Yes ☐ No ☐ Hysterectomy? Yes ☐ No ☐
Ovaries removed? Yes ☐ No ☐
Absence of Menstruations (other than pregnancy or menopause)? Yes ☐ No ☐
Hormone Therapy (if applicable)? ☐ Yes ☐ No When? _____ Type? _____

Medical History:
Previous Bone Density Study? Where? _____ When? _____
Radiology Scan with contrast (MRI, PET, CT) within the last week? ☐ Yes ☐ No
Have you had a calcium pill today? ☐ Yes ☐ No Family History of Osteoporosis? Yes ☐ No ☐
Taken Cortisone or Prednisone orally for over 3 months? Yes ☐ No ☐
Hip or Joint replacement surgery? Yes ☐ No ☐ If so, which one? _____
Lower back surgery? ☐ Yes ☐ No

Check all other medical conditions that apply:
☐ Bone Disease ☐ Parathyroid disorder ☐ Eating disorder ☐ Fall in the past year ☐
☐ Osteoporosis ☐ Hypothyroid ☐ Lupus ☐ Asthma ☐
☐ Kidney Disease ☐ Hyperthyroid ☐ Chronic steroid use ☐ Low Bone Density ☐
☐ Rheumatoid arthritis ☐ Hypothalamic Amenorrhea Type and duration:
☐ Diabetes I / II ☐ Celiac disease _____
☐ Cancer. Type:
_____ ☐ Bone Fracture:
Chemotherapy? ☐ Yes ☐ No Which bone? _____

Current Medications
☐ Estrogen ☐ Progesterone ☐ Lupon ☐ Zoladex ☐ Cortisone ☐ Prednisone ☐ Tamoxifen ☐ Decadron
☐ Fosamax/Alendronate ☐ Fosamax D ☐ Boniva ☐ Actonel ☐ Evista ☐ Zometa ☐ Reclast
SSRI's: ☐ Lexapro ☐ Prozac ☐ Zoloft Additional medications: _____

Risk Factors:
☐ Take Supplemental Calcium? _____ ☐ Lift weights weekly? How many days: _____
☐ Take Vitamin D? _____ Currently smoke cigarettes? How many packs/day? _____
☐ Perform cardio exercises weekly? _____ Smoked in the past? How long/much? _____
☐ Alcohol consumption? Drinks/Week? _____

Signature:
_____