Sports Medicine North Bone Density Questionnaire

Name (print):_____Date: _____

Is there a chance that you are pregnant? ☐ Yes ☐ No
Have you had a barium X-ray in the last 2 weeks? ☐ Yes ☐ No
Have you had a nuclear medicine scan or injection of an X-ray dye in the last week? ☐ Yes ☐ No
Have you had hyperparathyroidism or a high calcium level in your blood? ☐ Yes ☐ No

If you answered yes to any of the above, speak to our receptionist right away.

1. Your: Age:_____ Sex: ☐ Male ☐ Female

2. Your ethnicity (check one):
☐ Caucasian (White) ☐ Black ☐ Asian
☐ Aboriginal ☐ Hispanic ☐ Other

3. Have you ever had a bone density test? ☐ Yes ☐No
If YES, when and where? _____

4. Have you had a recent weight change? ☐ Yes ☐ No
If YES, tell us about it: _____

5. Your tallest height (late teens or young adult): _____

6. Have you ever broken a bone as an ADULT? ☐ Yes ☐ No

Bone broken?	**Simple fall?**	**If not a simple fall, please describe the circumstances**	**Age when break occurred?**

7. Has a parent or sibling had a broken hip or other bone from a simple fall or bump? ☐ Yes ☐ No
8. Has a parent or sibling ever been diagnosed with osteoporosis? ☐ Yes ☐ No
9. How many times have you fallen in the last year? _____

10. Have you ever had surgery of the spine, hips, legs or arms? ☐ Yes ☐No
If YES, describe what type of surgery you had and which side was affected

_____

_____

11. Are you currently receiving or have you previously received prednisone pills (cortisone)?

☐ Yes, currently ☐ Yes, previously ☐ No

If YES, for how long? _____ Dosage? _____mg or _____pills each day

12. List any chronic medical conditions that you have: *(esp. Alcoholism, Anorexia Nervosa, bad kidney function, intestinal malabsorption, etc.)*

_____

_____

13. Do you exercise on a regular basis ☐ Yes ☐ No

If YES, how many times per week? _____

14. Do you take any calcium supplements and/or eat a calcium rich diet?

☐ Yes ☐ No

How many mg. of calcium do you take in each day? _____ mg

15. Do you take any vitamin D supplements (including multivitamins in your calcium supplement and/or halibut liver oil)? ☐ Yes ☐ No

16. Do you smoke? ☐ Yes ☐ No

If YES, how much? ☐ ½ pack ☐ 1 pack ☐ >1 ½ packs daily

For women only…

17. Are you still having menstrual periods? ☐ Yes ☐ No

18. Before menopause, have you ever missed your periods for 6 months or more, besides during pregnancy? ☐ Yes ☐ No

19. Have you had your menopause? ☐ Yes ☐ No

If YES, at what age? _____

20. Have you had a hysterectomy? ☐ Yes ☐ No

If YES, at what age? _____

21. Have you had both of your ovaries removed? ☐ Yes ☐ No

If YES, at what age? _____

22. Age onset of menstruation? _____

23. Have you ever been prescribed any of the following medications?

If YES, are you currently still taking it and for how long have you been prescribed it?

Medication	**Ever?**	**Currently Taking**	**If current, how long?**
Hormone replacement therapy	☐ Yes ☐ No	☐ Yes ☐ No	
Nolvadex® (Tamoxifen)	☐ Yes ☐ No	☐ Yes ☐ No	
Evista® (Raloxifene)	☐ Yes ☐ No	☐ Yes ☐ No	
Depo-Provera®	☐ Yes ☐ No	☐ Yes ☐ No	
Didronel®/Didrocal® (Etidronate)	☐ Yes ☐ No	☐ Yes ☐ No	
Fosamax® (Alendronate)	☐ Yes ☐ No	☐ Yes ☐ No	
Actonel® (Risedronate)	☐ Yes ☐ No	☐ Yes ☐ No	
Boniva®	☐ Yes ☐ No	☐ Yes ☐ No	
(Aredia® Intravenous pamidronate	☐ Yes ☐ No	☐ Yes ☐ No	
Miacalcin® nasal spray (Calcitonin)	☐ Yes ☐ No	☐ Yes ☐ No	
Forteo®	☐ Yes ☐ No	☐ Yes ☐ No	
Bonefos®, Ostac® (Clodronate)	☐ Yes ☐ No	☐ Yes ☐ No	
Anti-Stomach Acid Medication	☐ Yes ☐ No	☐ Yes ☐ No	
Thyroid Hormone	☐ Yes ☐ No	☐ Yes ☐ No	
Medication for seizures or epilepsy	☐ Yes ☐ No	☐ Yes ☐ No	
Chemotherapy for cancer	☐ Yes ☐ No	☐ Yes ☐ No	
Medication to prevent organ transplant rejection	☐ Yes ☐ No	☐ Yes ☐ No	
Medication for prostate cancer	☐ Yes ☐ No	☐ Yes ☐ No	
Hydrochlorothiazide or any other diuretic	☐ Yes ☐ No	☐ Yes ☐ No	