Good Samaritan Hospital Medical Center
Catholic Health Services
At the heart of health

Bone Density
Patient History Questionnaire

Name: _____ Today's Date: _____

DOB: _____ Current Height: _____

Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Other ☐ Asian Current Weight: _____

Menopause Age: _____ Last Menstrual Period: _____

1. Previous hip or vertebral fracture? ☐ Yes ☐ No
2. Treatment for osteoporosis within the past 2 years? ☐ Yes ☐ No
3. Premenopausal woman? ☐ Yes ☐ No
4. Previous fracture after age 40 (not trauma-related)? ☐ Yes ☐ No
5. Parental fractured hip? ☐ Yes ☐ No
6. Current smoker? ☐ Yes ☐ No
7. Glucocorticoids (steroids)? ☐ Yes ☐ No
8. Rheumatoid arthritis? ☐ Yes ☐ No
9. Secondary osteoporosis? ☐ Yes ☐ No
10. Alcohol 3 or more units per day? ☐ Yes ☐ No
11. Did you have a nuclear medicine or barium contrast study in the last 7 days? ☐ Yes ☐ No
12. Have you had a previous dexa scan? ☐ Yes ☐ No

    If yes, where? _____
13. Any family history of osteoporosis? ☐ Yes ☐ No
14. Have you had a total hip replacement? If yes: ☐ left ☐ right or ☐ both? ☐ Yes ☐ No
15. Any lower back surgery? ☐ Yes ☐ No
16. Any spinal surgery requiring hardware? ☐ Yes ☐ No
17. Please list any prescription medications: _____

    _____

    _____
18. Please list any medical conditions you have ever been diagnosed with: _____

    _____

    _____

    _____

Patient Signature	Date	Time
Technologist Signature	Date	Time

DO NOT WRITE IN THIS AREA

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