Montclair
Breast
Center

# BONE DENSITY QUESTIONNAIRE

Please answer the following questions. If you are not sure how to answer a question, leave the space blank and we will assist you with the answer when you are seen at our facility. All answers will be kept in strict confidence and treated as medical record information. Bring with you or fax to our office at 973-509-0932.

1. Name ____________________

2. Date of Birth ____________________

3. Height ____________________ Weight ____________________

4. Race
African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other ☐

5. Sex: Female ☐ Male ☐

6. Referring Physician ____________________

| | Yes | No |
|---|---|---|
| 7. Have you fractured any bones during your ADULT life? | ☐ | ☐ |
| 8. Does your family have a record of osteoporosis? | ☐ | ☐ |
| 9. Do you smoke more than a half a pack of cigarettes per day? | ☐ | ☐ |
| 10. Have you smoked in the past? | ☐ | ☐ |
| 11. Do you have three or more dairy servings per day every day? (One serving = 8 oz. Milk, 1.5 oz. Cheese, 8 oz. Yogurt, 8 oz. Cottage Cheese, or 4 oz. Ice cream) | ☐ | ☐ |
| 12. Have you consumed three or more dairy servings per day throughout most of your life? | ☐ | ☐ |
| 13. Do you take calcium supplement daily? | ☐ | ☐ |
| If so, how much? 0-500 mg/day 501-1000 mg/day >1000 mg/day | | |
| 14. Do you exercise at least three times per week? | ☐ | ☐ |
| 15. Do you drink more than two alcoholic beverages per day? | ☐ | ☐ |
| 16. Have you take any of the following medications or treatments? | | |
| a. Steroids (prednisone, cortisone etc.), including inhaled steroids | ☐ | ☐ |
| b. Thyroid medication | ☐ | ☐ |
| c. Anticonvulsants (for seizures, epilepsy) | ☐ | ☐ |
| d. Loop diuretics (Lasix, Bumex, Edecrin) | ☐ | ☐ |
| e. Heparin | ☐ | ☐ |
| f. Chemotherapy | ☐ | ☐ |
| g. Lithium | ☐ | ☐ |
| h. Evista, Fosamax, or Actomel | ☐ | ☐ |
| i. Nasal spray for osteoporosis (Miacalcin) | ☐ | ☐ |
| 17. Have you had any of the following conditions? | Yes | No |

| | Yes | No |
|---|---|---|
| a. Hyperthyroidism or Hyperparathyroidism | ☐ | ☐ |
| b. Biliary Cirrhosis | ☐ | ☐ |
| c. Kidney disease | ☐ | ☐ |
| d. Rheumatoid arthritis | ☐ | ☐ |
| ve. Other arthritis | ☐ | ☐ |
| f. Part of the stomach removed | ☐ | ☐ |
| g. Intestinal or bowel disease | ☐ | ☐ |
| h. Eating disorders (anorexia, bulimia, etc.) | ☐ | ☐ |
| i. Surgery of the spine hips | ☐ | ☐ |
| j. Total joint replacements | ☐ | ☐ |

18. Do you have any general comments or questions about your health? ______________________________

________________________________________________________________________________

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________________________________________________________________________________

**********************REMAINING QUESTIONS FOR WOMEN ONLY**********************

| | Yes | No |
|---|---|---|
| 19. Have you gone through menopause? | ☐ | ☐ |
| 20. Did your menopause occur before age 45? | ☐ | ☐ |
| 21. Have you ever had amenorrhea (missed periods or never started periods)? | ☐ | ☐ |
| 22. Have you ever taken female hormones (not including birth control pills)?<br>If so, for how many years? ________________ | ☐ | ☐ |
| 23. Have you ever had any of the following side effects from hormones? | | |
| a. Breast tenderness | ☐ | ☐ |
| b. Heavy periods or intermittent bleeding/spotting | ☐ | ☐ |
| c. Headaches | ☐ | ☐ |
| d. Weight gain or fluid buildup | ☐ | ☐ |
| e. Other ____________________________________________________ | ☐ | ☐ |
| 24. Have you ever had osteoporosis or weak bones?<br>If so, what was the treatment? ______________________________________________ | ☐ | ☐ |
| 25. Have you had any of the following conditions? | ☐ | ☐ |
| a. Hysterectomy (womb removed) | ☐ | ☐ |
| b. Ovaries removed | ☐ | ☐ |
| c. Blood clots | ☐ | ☐ |
| If yes, were you on hormones at the time? | ☐ | ☐ |
| d. Breast cancer | ☐ | ☐ |
| e. Family history of breast cancer | ☐ | ☐ |
| f. Cancer of the uterus (womb) | ☐ | ☐ |