

HOBOKEN RADIOLOGY

Providing a clearer image of health

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BONE DENSITY QUESTIONNAIRE

MR# _____

OFFICE USE ONLY

Name: _____ D.O.B. _____ SEX: M F

ARE YOU PREGNANT OR POSSIBLY PREGNANT? YES NO

Height: _____ Weight: _____

Race: African American Asian Caucasian Hispanic Other

Have you gone through menopause? Yes No

Have you fractured any bones during your adult life?

Do you have a family history of osteoporosis?

Are you a smoker?

Do you take a calcium supplement daily?

0-500 mg/day 501-1000 mg/day >1000 mg/day

If so, did you discontinue your calcium for 24 hours?

Have you taken any of the following medications or treatments? *(check all that apply)*

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Steroids | <input type="checkbox"/> Thyroid Medication | <input type="checkbox"/> Heparin |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Diuretic (Lasix) | <input type="checkbox"/> Anticonvulsants |
| <input type="checkbox"/> Fosamax | <input type="checkbox"/> Actonel | <input type="checkbox"/> Miacalcin |
| <input type="checkbox"/> Hormones | | |

Have you had any of the following conditions? *(check all that apply)*

- | | | |
|--|---|--|
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Liver/Kidney Disease | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Intestinal Disease | <input type="checkbox"/> Part of Stomach Removed |

PATIENT SIGNATURE: _____ DATE: _____ TECHNICIAN: _____