

XRAY ASSOCIATES
 125 PEDERSEN DRIVE, UNIT #3,4,5
 AURORA, ON L4G 0E3
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Osteoporosis Questionnaire

Patient Name: _____

Weight: _____.

Height: _____.

Patient History:

1. Have you had a previous bone density exam here? Have you had a previous bone density at another location?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you had any surgery on your back? Have you had any surgery on your hips?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you had a nuclear medicine exam or x-ray exam with contrast material in the last 5 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you take calcium supplements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Are you taking, or have you ever taken, Fosamax or Didrocal or Evista or Actonel?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you been on Prednisone or steroid for a long period? If yes, for how long? _____. If yes, what was your dosage? _____.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you take medication for your thyroid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has anyone in your family had osteoporosis? If yes, who:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Female Patients Only:

10. Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Are you on hormone replacement therapy? If yes, what is your dosage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Are you post-menopausal (finished menses)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Have you had a hysterectomy? A) Ovaries & Uterus B) Uterus only If yes, when? _____.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No