Ocala Health
Advanced Imaging Centers

BONE DENSITOMETRY QUESTIONAIRE

Date: _____

Patient Name: _____ Acct: _____

1. Have you had a previous bone density? YES NO
   If yes, when _____ where _____
2. Have you started menopause? YES NO When _____
3. Have you had a previous Hysterectomy? YES NO Age: _____
4. Removal of one or both ovaries? YES NO
5. Have you ever broken your spine or hip? YES NO
   If yes, which side _____
6. Have you ever had surgery on your spine or hip? YES NO
   If yes, which side _____
7. What is your ethnic background? _____
8. Is there a family history of osteoporosis? YES NO
9. Are you currently undergoing treatment for osteoporosis? YES NO
   Specify: _____
10. Have you been taking any of the following medications? YES NO

Calcium	___	Hormones	___
Non hormonal medications	___	Steroids	___
Anticonvulsants	___	Antacids	___

11. Do you smoke? YES NO How many per day? _____
12. Have you had a nuclear medicine bone scan in the last 7 days? YES NO
13. Have you had a barium test/ meal or enema in the last 7 days? YES NO

Tech Initials: _____