Developed by Diane Thériault for the Canadian Panel, International Society for Clinical Densitometry, April, 2004

Patient Questionnaire

Name (print):_____ Date: _____

Is there a chance that you are pregnant? Yes No
Have you had a barium X-ray in the last 2 weeks? Yes No
Have you had a nuclear medicine scan or injection of an X-ray dye in the last week? Yes No
Have you had hyperparathyroidism or a high calcium level in your blood? Yes No

If you answered yes to any of the above, speak to our receptionist right away.

1. Your: Age: ____ Sex: Male Female

2. Your ethnicity (check one):
__Caucasian (White) __Black __Aboriginal __Asian __Hispanic __Other
Your country of birth: _____

3. Have you ever had a bone density test? Yes No
If YES, when and where? _____

4. Have you had a recent weight change? Yes No
If YES, tell us about it: _____

5. Your tallest height (late teens or young adult): _____

6. Have you ever broken a bone? Yes No

Bone broken	Simple fall?	If not a simple fall, please describe the circumstances	Age when this occurred

7. Has a parent or sibling had a broken hip from a simple fall or bump? Yes No

8. Has a parent or sibling had any other type of broken bone from a simple fall or bump? Yes No

9. How many times have you fallen in the last year? _____

10. Have you ever had surgery of the spine, hips, legs or arms? Yes No
If YES, describe what type of surgery you had and which side was affected
_____
_____

11. Are you currently receiving or have you previously received prednisone pills (cortisone)?
Yes, currently ____ Yes, previously _____ No ____
If YES, for how long? _____ What is your dose? _____mg or _____ pills each day

12. List any chronic medical conditions that you have:
_____ _____
_____ _____
_____ _____

13. Are you currently receiving or have you previously received any of the following medications?

	No	Yes	For how long?
Medication for seizures or epilepsy			
Chemotherapy for cancer			
Medication for prostate cancer			
Medication to prevent organ transplant rejection			

14. Have you been treated with any of the following medications?

Medication	Ever?	Currently?	If current, how long?
Hormone replacement therapy (Estrogen)			
Tamoxifen			
Raloxifene (Evista)			
Testosterone			
Etidronate (Didronel/Didrocal)			
Alendronate (Fosamax)			
Risedronate (Actonel)			
Intravenous pamidronate (Aredia)			
Clodronate (Bonefos, Ostac)			
Calcitonin (Miacalcin nasal spray)			
PTH (Forteo)			
Zoledronic acid (Zometa)			
Sodium fluoride (Fluotic)			

15. How many servings of the following do you eat/drink per day (on average)?

	Milk (full cup)	Orange juice fortified with calcium (full cup)	Yogurt (small container or ½ cup)	Cheese
Number of servings				

16. Do you take any calcium supplements (including TUMS)? Yes No

17. Do you take any vitamin D supplements (including multivitamins and halibut liver oil)? Yes No

18. Do you smoke? Yes No

For women only…

19. Are you still having menstrual periods? Yes No

20. Before menopause, have you ever missed your periods for 6 months or more, besides during pregnancy? Yes No

21. Have you had your menopause? Yes No
    If yes, at what age? _____

22. Have you had a hysterectomy? Yes No
    If YES, at what age? _____
    Have you had both of your ovaries removed? Yes No
    If YES, at what age? _____