BONE DENSITY PATIENT HISTORY QUESTIONAIRE

The Breast Care & Bone Density Centre
Ground Floor - JHB Eye Hospital
13 Waugh Ave, Northcliff, Gauteng 2195
011 782 7345

Name		**Today's date**	
Patient ID		**Sex**	
Current height (cm)		**Date of birth**	
Weight (cm)		**Referring Physician**	
Menopause Age		**Are you pregnant?**	

1. Have you had a previous hip or vertebral fracture?	Yes	No
2. Have you had any fractures during adult life which did not result from significant trauma?	Yes	No
3. Did either of your parents ever have a hip fracture?	Yes	No
4. Do you smoke?	Yes	No
5. Have you ever taken Glucocorticoids?	Yes	No
6. Do you have Rheumatoid arthritis?	Yes	No
7. Do you have secondary osteoporosis (disorders: diabetic / osteogenesis / hyperthyroidism / hypogonadism / menopause < 45y/ malabsorption / liver disease & malnutrition)?	Yes	No
8. Do you drink 3 or more alcoholic drinks per day?	Yes	No
9. Are you being treated for osteoporosis?	Yes	No
10. Have you ever taken one of the following medications?	Yes	No
Actonel Reclast Boniva Protelos Evista Vit D Forteo Prolia Fosamax Other HRT Calcium Miacacin		
11. Do you have any of the following medical conditions:	Yes	No
Anorexia/Bulimia Any Seizure disorder Asthma/Emphysema Cancer End stage renal disease Inflammatory bowel disease Hyperparathyroidism Hysterectomy Other		
12. What was your max height?		
13. Do you perform weight bearing exercise regularly?	Yes	No
14. Do you regularly consume dairy products?	Yes	No
15. Do you drink caffeinated beverages?	Yes	No
16. Any contrast examination in last 7 days (Iodine/Barium)	Yes	No

If Female:

17. At what age did your period start?		
18. Are you menopausal?	Yes	No
19. How many full-term pregnancies have you had?		
20. Have you missed a period recently?	Yes	No