

RUSH OSTEOPOROSIS CENTER
1611 W. Harrison Street, Suite 510, Chicago, IL 60612
Phone: 312-563-2266 Fax: 312-563-2975
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

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

1 Your: Age _____ Sex Male Female Height _____ Weight _____

2 Your ethnicity (check one):
 _____ Caucasian (White) _____ Black _____ 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

Patient Questionnaire (page 2)

12 Have you had hyperparathyroidism or a high calcium level in your blood? Yes No

13 Do you have rheumatoid arthritis? Yes No

14 Do you have any of the following conditions? (circle all that apply)

- | | |
|---|---------------------------------------|
| Type 1 (insulin dependent) diabetes | Osteogenesis imperfecta |
| Untreated long-standing hyperthyroidism | Hypogonadism |
| Premature menopause (<45 years) | Chronic malnutrition or malabsorption |
| Chronic liver disease | |

15 List any chronic medical conditions that you have:

_____	_____
_____	_____
_____	_____

16 Have you ever had a blood clot? Yes No

17 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			

18 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) (Reclast)			
Sodium fluoride (Fluotic)			
Ibandronate (Boniva)			

Patient Questionnaire (page 3)

19 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				

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

21 Do you take any vitamin D supplements (including multivitamins)? Yes No

22 Do you smoke? Yes No

23 Do you have 3 or more units of alcohol per day? This is equivalent to a standard glass of beer (285ml), a single measure of spirits (30ml) or a medium sized glass of wine (120ml). Yes No

For women only...

24 Are you still having menstrual periods? Yes No

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

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

27 Have you had a hysterectomy?
If YES, at what age? _____ Yes No

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

I understand that I am providing this information to assist in the interpretation of my bone density results and a copy of this questionnaire will accompany the results sent to my referring physician.

Signature _____

Date _____