



7135 Perkins Road - Baton Rouge, LA 70808 ♦ 225.765.8600

Bone Density Screening Questionnaire

Name: _____ Date of Birth: _____

- Yes No Do you consider yourself to have a small thin frame?
- Yes No Are you Caucasian? Yes No Are you Asian?
- Yes No Is your diet low in dairy products and other sources of calcium?
- Yes No Are you physically inactive?
- Yes No Do you smoke cigarettes or drink alcohol in excess?
- Yes No Are you postmenopausal?
- Yes No Do you experience flushing, sleeplessness, headaches, or a lack of concentration associated with menopause?
- Yes No Have you had an early menopause?
- Yes No Have you had a surgically induced menopause?
- Yes No Are you on hormone replacement therapy?
- Yes No Do you have hyperparathyroidism (different than hyperthyroidism)?
- Yes No Do you have a family history of osteoporosis?
- Yes No Do you have osteoporosis?
- Yes No Have you completed drug therapy for osteoporosis?
- Yes No Do you have osteopenia documented by previous testing?
- Yes No Have you taken long-term thyroid medication?
- Yes No Have you taken long term cortisone steroids? (i.e. medication for asthma, arthritis, or MS)
- Yes No Do you have a nontraumatic fracture (not involving injury)?
If yes, please specify area _____
- Yes No Do you have a current vertebral (spinal) fracture due to injury?
- Yes No Do you have a history of compression fractures of the spine?

List any illness for which you have been, or are currently being treated for with medication below.

Signature: _____

Date: _____