ConnectCare & Wellness Bone Density Questionnaire

PatientName:	Dateof Birth:
TallestHeight(youngadult)(in.):	CurrentHeight(in)
CurrentWeight(lbs.)	Gender:FemaleorMale
Ethnicity(circle):Asian African/Amer Hispanic White Other	
Date:	

History	YES	IFYES	NO
Fractureafterageof 50?		Listwhich bone?	
HasaParenthadahip fracture?		**Circle** Mother Father	
LowerbackorHip Surgery?		**Circle** LowerBack Hip	
Doyou smoke?			
Steroid USE? (Example-Prednisone for more than 3 months)			
Do you have RheumatoidArthritis?			
Morethan3alcohol drinks/day?			
DoyouhaveLiver Disease?			
DoyouhaveType1 diabetes?			
Do you have Osteogenesis Imperfecta?			
Do you have malabsorption?			
Do you have hyperparathyroidism?			
DoyoutakeCalcium Supplements?		_____ mg/day	
DoyoutakeVitaminD Supplements?		_____ mg/day	
FemalePatients			
Doyoustillgeta period?		LMP:	
Haveyouhada hysterectomy?		When?	
Haveryourovaries been removed?		When?	

Medications	YES	IFYES When/How Long	NO
Actonel (Risedronate)			
Atelvia			
Boniva			
Estrogen			
Fosamax (Alendronate)			
Forteo			
Prolia			
Reclast			
Anticonvulsant (Seizuremed)			
ThyroidMed			
Tamoxifen, Arimidex,Femara			
Depo-Provera shots			
Lupron			
Testosterone			
Other:			

Notes:

Technologist initials: