

IMAGECARE

Osteoporosis Questionnaire

Name _____ Male - Female _____ Date: _____

Date of Birth _____ Referring Physician _____

Have you had a previous DEXA Scan? ** Yes No

 ** When _____ Where _____

Are you RIGHT or LEFT handed _____

Have you been diagnosed with having Osteoporosis? Yes No

Have you been diagnosed with having Osteopenia? Yes No

Mature Adult Height _____ Present Height _____ Weight _____

Check any of the following that apply to you

- Surgery on your back
- Surgery on either hip Right Left
- Thyroid disease/dysfunction
- Parathyroid disease
- Diabetes
- Kidney or liver disease
- Paget's disease
- Cushing's syndrome
- Cancer – Type and date diagnosed _____
 - Chemotherapy? Yes No Radiation Therapy? Yes No
- Organ transplant
- Family history of osteoporosis
- Broken bones as an adult. Body part and date of injury _____

Medications

- Steroids months _____
- Thyroid medications months _____
- Hormones months _____
- Calcium supplements months _____

- Vitamin D months _____
- Evista (Raloxifene) months _____
- Fosamax (Alendronate) months _____
- Other osteoporosis therapy medication months _____

For Women Only

- Have you had a hysterectomy? No Yes Age _____
- Have you had your ovaries removed? No Yes Age _____
- Have you gone through menopause? No Yes Age _____