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BONE DENSITY QUESTIONNAIRE

Name: _____

Contact Phone Number: _____

Date of Birth: _____

Primary Care Physician: _____

Today's Date: _____

If applicable, date of last bone density scan and location where it was done: _____

Current Medications: _____

Age: _____ Weight: _____ Height: _____ Last menstrual period: _____

Please check all of the following that apply to you:

- 1. Female
- 2. Post menopausal or ovaries removed less than age 50
- 3. Taking estrogen
- 4. If female, have never been pregnant
- 5. If not post-menopausal or pregnant, have had periods that have stopped for more than 6 months in a row
- 6. If male, have had decreased testosterone levels
- 7. Caucasian or Asian
- 8. Family history of osteoporosis
- 9. Ancestors from Northern Europe, British Isles, China, or Japan
- 10. Small body frame
- 11. Light hair, fair complexion, or freckles
- 12. Consume fewer than 3 dairy servings a day
- 13. Do not take Calcium Supplement
- 14. Drink 3 or more cups of coffee, tea, or soda a day
- 15. Drink alcohol more than 2 times a day
- 16. Smoker, either now or in the past
- 17. Weight-bearing exercise less than 3 times per week
- 18. Personal history of fractures after a minor fall or bump
- 19. Have taken steroids for 3 months or longer
- 20. Have taken thyroid replacement hormone
- 21. Have taken seizure medications
- 22. Have kidney problems, liver problems, or inflammatory bowel disease
- 23. Have Diabetes Mellitus
- 24. Have lost more than 1 1/2 inches in height
- 25. Have other known risk factor for osteoporosis not listed above