ImageCare, LLC
710 Rabon Road, Columbia, SC 29203
Bone Density Patient History Questionnaire

Name:_______________________________________ Date:_____________________________
Patient ID:___________________________________ Sex: _____________________________
Current Height:________________________________ Date of Birth:______________________
Weight:_______________________________________ Referring Physician:_________________
Menopause Age:_______________________________ Race:_____________________________

1. Have you had a previous hip or vertebral fracture? _____Yes _____No
2. Have you had any fractures during your adult life which did not result from significant trauma (e.g., auto accident)? _____Yes _____No
3. Did either of your parents ever have a hip fracture? _____Yes _____No
4. Do you smoke? _____Yes _____No
5. Have you ever taken steroids for 3 months or longer? _____Yes _____No
6. Do you have rheumatoid arthritis? _____Yes _____No
7. Have you been diagnosed with osteoporosis (primary or secondary) _____Yes _____No
8. Do you drink 3 or more alcoholic drinks per day? _____Yes _____No
9. Are you being treated for osteoporosis? _____Yes _____No
10. Have you ever had back surgery? _____Yes _____No
11. Have you ever had hip surgery? _____Yes _____No

12. Have you ever taken any of the following medications?
    _____ Actonel (i.e. Risedronate)
    _____Evista (i.e. raloxifene)
    _____Fosamax (i.e. alendronate)
    _____Miacalcin (i.e. calcitonin)
    _____Reclast (i.e. zoledronate)
    _____Vitamin D
    _____Boniva (i.e. ibandronate)
    _____Forteco (i.e. parathyroid hormone)
    _____HRT (i.e. estrogen/hormone therapy)
    _____Protelos (i.e. strontium ranelate)
    _____Prolia (i.e. denosumab)
    _____Calcium
    _____Other – please specify ____

13. Do you have any of the following medical conditions?
    _____Anorexia or Bulimia
    _____Asthma or Emphysema
    _____End stage renal disease
    _____Hyperparathyroidism
    _____Any Seizure Disorders
    _____Cancer
    _____Inflammatory bowel diseases
    _____Hysterectomy
    _____Other – please specify____

14. What was your maximum height (inches)? ___________________________________
15. Do you perform weight bearing exercises regularly? _____Yes _____No
16. Do you regularly consume dairy products? _____Yes _____No
17. Do you drink caffeinated beverages? _____Yes _____No

If Female:

18. At what age did your period start? _______________________________________
19. Are you pre-menopausal? _____Yes _____No
20. How many full term pregnancies have you had? _____________________________
21. Have you ever missed your period for more than 6 months in a row (not including pregnancy of menopause)? _____Yes _____No

_______________________________________ ____________________
Patient Signature Date

5/3/18