CEDARS-SINAI®

S. MARK TAPER FOUNDATION
IMAGING CENTER

BONE DENSITY QUESTIONNAIRE

PATIENT I.D.

1. Do you have Personal or Family History of the following conditions? *(please check all that apply)*

Personal	Family		Personal	Family	
❑	❑	Cancer	❑	❑	Chronic Renal Failure
❑	❑	Crohn's Disease	❑	❑	Cushing's Disease
❑	❑	Ulcerative Colitis	❑	❑	Fractures *(not caused by trauma)*
❑	❑	Hyperprolactinemia	❑	❑	Hyperparathyroidism
❑	❑	Testicular Hypofunction	❑	❑	Osteoporosis
❑	❑	Growth Hormone Deficiency	❑	❑	Thyroid Disorder

Are you perimenopausal? ❑ Yes ❑ No
Are you in menopause? ❑ Yes ❑ No
Do you have back pain? ❑ Yes ❑ No
Do you have hip pain? ❑ Yes ❑ No ❑ Right ❑ Left
Do you have joint pain? ❑ Yes ❑ No If yes, *specify*: ____________________

2. Are you taking any of the following Medications?

❑ Hormones ❑ Prednisone *(steroids)*
❑ Thyroid medication(s) ❑ Fosamax
❑ Calcium ❑ Chemotherapy
❑ Other: ____________________

3. Did you ever have a Hip Replacement?

❑ No ❑ Yes: Right _____ Left _____

4. Did you have a X-Ray exam with contrast in the past week *(i.e. CT scan)*?

❑ No ❑ Yes, *please describe* ____________________

5. Did you have a Nuclear Medicine exam in the past week *(i.e. Bone Scan, PET scan)*?

❑ No ❑ Yes, *please describe* ____________________

NAME OF PATIENT (please print)		SIGNATURE OF PATIENT	DATE	TIME
NAME OF STAFF (please print)	TITLE	SIGNATURE OF STAFF	DATE	TIME