COLUMBIA PRESBYTERIAN EASTSIDE RADIOLOGY
16 East 60th Street
New York, NY 10022

BONE DENSITOMETRY QUESTIONNAIRE

NAME__________________________________ AGE ______ SEX ________

HAVE YOU HAD THIS TEST BEFORE? YES( ) NO ( )

WHERE _________________________________ WHEN ____________

DATE OF LAST MENSTRUAL PERIOD:___________________

ARE YOU OR COULD YOU BE PREGNANT? YES ( ) NO ( )

PLEASE LIST ALL FRACTURES AND AGE AT WHICH THEY OCCURRED____
____

PLEASE LIST ALL MEDICATIONS (including vitamins, supplements, etc.)
____
____

HAVE YOU A HISTORY OF (please check all that apply)
Severe menstrual irregularity when younger__________
Eating disorder (anorexia)__________
Hyperthyroidism (over active thyroid)__________
Hyperparathyroidism_________
Diabetes________ (age at onset) _________
Adrenal gland disease (Cushing's or Addison's disease)________
Epilepsy_________
Kidney disease________
Liver disease_________
Gastro-intestinal disease with severe diarrhea, malabsorption, etc._________
Cigarette smoking________(how many packs per year)______(how many years)__________
Do you drink alcoholic beverages__________(how often and how much)_______________
Other serious illness________________(please specify)_____________________________

DO YOU TAKE OR HAVE YOU TAKEN FOR A LONG PERIOD (please check all that apply)
Synthroid or other thyroid medication______________
Cortisone______________
Dilantin_______________
Lupron________________
Heparin_______________