

**COLUMBIA PRESBYTERIAN EASTSIDE RADIOLOGY**  
**16 East 60<sup>th</sup> 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 \_\_\_\_\_

Tech Signature/Date: \_\_\_\_\_