

Health Record #: _____	Complete or place barcoded patient label here
Patient Name: <i>(Print first, last)</i> _____	
DOB: <u>dd</u> / <u>mm</u> / <u>yy</u>	Age: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male
OHIP #: _____	Version Code: _____
Account #: _____	Date of Admission: <u>dd</u> / <u>mm</u> / <u>yy</u>

Bone Mineral Density Patient Questionnaire

This document will be reviewed with you. A staff member will measure your height and weight.

1. Is there any chance that you are pregnant? Yes No
2. Date of last menstrual cycle? dd / mm / yy
3. Have you had a barium enema or barium drink in the last 2 weeks? Yes No

The following information will help us to assess your future risk for fracture.

1. Have you ever had surgery of the spine or hips? Yes No **If yes, was surgery due to** Fracture Arthritis
2. Have you ever broken any bones over the age of 40? Yes No

If yes, please state:

Bone Broken	Cause of Broken Bone

3. Have you taken steroid pills (such as prednisone or cortisone) for more than 3 months in the last 12 months? Yes No

If yes, are you currently taking steroid pills? Yes No

How long have you been taking them? _____

What is your current dose? _____

4. Have you ever been treated with medication(s) for osteoporosis? Yes No

If yes, which medications(s) and for how long?

Technologist Name: *(print first, last)* _____

Technologist Signature: _____

Date: dd / mm / yy

Time: _____

