



BONE MINERAL DENSITOMETRY QUESTIONNAIRE

FOR YOUR PERSONAL SAFETY, ALL OF THE QUESTIONS BELOW MUST BE COMPLETED BEFORE AN MRI SCAN CAN PROCEED

FIRST NAME: _____ SURNAME: _____
D.O.B. ____/____/____ OCCUPATION: _____ WEIGHT: _____ kg HEIGHT: _____ cm

Please tick either Yes or No.

Do you have or have you had any of the following?

- Have you had a Bone Mineral Densitometry before today? YES NO
Where? When?
- Have you ever broken a bone as a result of minimal trauma in the last 5 years? YES NO
(i.e. coughing, fall from standing or crush fracture of the spine)
- Have you been medically diagnosed with osteoporosis? YES NO
- Do you take any medications for bone health? YES NO
Please list.....
- MALES: Have you been medically diagnosed with Hypogonadism? YES NO
- FEMALES: Did you progress through the menopause before the age of 44.5yrs? YES NO
If yes, please specify age
- Undergo a total Hysterectomy and oophorectomy before 44.5yrs? YES NO
- Have been diagnosed with amenorrhea before 44.5yrs? YES NO
- Are you on any long term steroid, glucocortoid or cortisone medication? YES NO
(including asthma inhalers used daily for more than 3 months)

Have you been medically diagnosed with any of the following?

- Hyperthyroidism YES NO
- Hyperparathyroidism YES NO
- Rheumatoid arthritis YES NO
- Chronic liver disease YES NO
- Chronic kidney disease YES NO
- Crohns disease YES NO
- Coeliac disease YES NO
- Any malabsorption problems not stated above YES NO
- Have you had any surgery to your lower back, hips or wrist? YES NO
- If **YES**, please specify: _____
- Have you been diagnosed with diabetes? Please specify Type I/Type II YES NO
- Are you a current smoker? YES NO
- Do you drink more than 3 standard measures of alcohol per day? YES NO
- Have either parent had a HIP fracture? YES NO

Signature Date/...../.....