Irish Osteoporosis Society

BONE MINERAL DENSITY QUESTIONNAIRE - FEMALE

This questionnaire consists of **FOUR** pages. Please answer **ALL** questions.

Patients Details

Date: / /

Name:

Address:

Telephone: Mobile:

Doctors Name:

Sex: M ☐ F ☐ Age: Date of Birth:

Height: Weight:

Occupation:

Why are you having a Dexa Scan?

Social Status: Med. Card Non-Med Card

Marital Status: Have you had any children? Yes ☐ No ☐

Full Term: Miscarriage:

Spontaneous Abortion: Stillbirth:

Exercise History

Exercise history now: Type Minutes/Day:

In the past: Type Minutes/Day:

Are you or were you ever a competitive athlete? Yes ☐ No ☐

If yes, at what level?

Do you require dental treatment? Yes ☐ No ☐

Dietary History

Vegetarian: Yes ☐ No ☐ Vegan: Yes ☐ No ☐

How many years? What age did you start?

Was your childhood diet: Good ☐ Bad ☐

Dietary Calcium: Milk: Yes ☐ No ☐ Total milk Per day

If yes, Type: Supermilk ☐ Regular ☐ Low Fat ☐ Soya ☐

Cheese: Per week Yogurt: Per week

Do you eat everything? Yes ☐ No ☐

If no, what do you not eat?

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Do you have a history of eating disorders: Yes ☐ No ☐

If yes: Anorexia: Yes ☐ No ☐ What age did you start? _____

Bulimia:Yes ☐ No ☐ Frequent Dieting: Yes ☐ No ☐

How much coffee do you drink? Instant _____ Per day Percolated _____ Per day

How much tea do you drink? _____ Per day Weak: Yes ☐ No ☐ Strong: Yes ☐ No ☐

How much water do you drink? _____ Per day

How much alcohol do you drink? _____ Units/week

History of smoking? Yes ☐ No ☐

If yes, what age did you start? _____ Stop? _____

How long? _____ How many a day? _____

Menstrual History

Age at menarche (First Period): _____

How long is/was your cycle from the beginning of one period to the next? _____ days

Are or were your periods always regular? Yes ☐ No ☐

If no, how long is or was your cycle? _____

Do or did you suffer from PMT? Yes ☐ No ☐

Do or did you suffer from amenorrhoea (No periods, not pregnant)? Yes ☐ No ☐

If so, for how long? _____

Age at menopause? _____

Symptomatic? Yes ☐ No ☐

Flushes	Yes ☐	No ☐
Sweats	Yes ☐	No ☐
Depression	Yes ☐	No ☐
Headaches	Yes ☐	No ☐
Lack of sleep	Yes ☐	No ☐

Medical History

Do you suffer from?

Varicose veins	Yes ☐	No ☐	Osteoarthritis	Yes ☐	No ☐
Phlebitis	Yes ☐	No ☐	Blood Disease	Yes ☐	No ☐
Deep Vein Thrombosis	Yes ☐	No ☐	Haemachromatosis	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Migraine	Yes ☐	No ☐
Type: _____			Hypertension	Yes ☐	No ☐
Radiation	Yes ☐	No ☐	Asthma	Yes ☐	No ☐
Chemotherapy	Yes ☐	No ☐	Hyperparathyroidism (Kidney Stones)		
Rheumatoid Arthritis	Yes ☐	No ☐		Yes ☐	No ☐

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Diabetes	Yes ☐	No ☐	Hiatus Hernia	Yes ☐	No ☐
Type: _____			Gastric Ulcer	Yes ☐	No ☐
Thyroid Disease	Yes ☐	No ☐	Liver Disease	Yes ☐	No ☐
High Cholesterol	Yes ☐	No ☐	Kidney Disease	Yes ☐	No ☐
Bloating of stomach after food	Yes ☐	No ☐	Hypogonadism	Yes ☐	No ☐
Constipation	Yes ☐	No ☐	Transplant	Yes ☐	No ☐
Diarrhoea	Yes ☐	No ☐	Depression	Yes ☐	No ☐
Malabsorption	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐
Coeliac	Yes ☐	No ☐	Stroke	Yes ☐	No ☐

Have you had excessive stress? Yes ☐ No ☐

Have you had surgery? Yes ☐ No ☐

If yes, what type and year? _____ /

Have you had a serious illness? Yes ☐ No ☐

If yes, what type and year? _____ /

Do you have a family history of heart disease? Yes ☐ No ☐

Do you have a family history of breast cancer? Yes ☐ No ☐

Do you have a family history of osteoporosis? Yes ☐ No ☐

Do you have a family history of osteopenia? Yes ☐ No ☐

Have you sustained any fractures (broken a bone) Yes ☐ No ☐

If yes, What bones _____ What year _____

Low trauma Yes ☐ No ☐

Have you had a fall or fallen in the last year? Yes ☐ No ☐

Have you lost height Yes ☐ No ☐

Have you had or have back pain? Yes ☐ No ☐

Medication

Are you or have you been on any of the following medications?

Calcium Yes ☐ No ☐

Vitamin D Yes ☐ No ☐

If yes, What prearation and for how long? _____

Vitamins: Yes ☐ No ☐

If yes, Which ones _____

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Anticoagulants: Yes ☐ No ☐

Aspirin Yes ☐ No ☐

Warfarin Yes ☐ No ☐

Heparin Yes ☐ No ☐

Other _____

Bisphosphonates Yes ☐ No ☐

If yes, Which and for how long : _____

Actonel Yes ☐ No ☐

Bonviva Yes ☐ No ☐

Fosamax Yes ☐ No ☐

Zolodronic Acid Yes ☐ No ☐

Are you taking Protelos? Yes ☐ No ☐

If yes, Which and for how long : _____

Are you on Forsteo? Yes ☐ No ☐

If yes, Which and for how long : _____

Anti-convulsive Yes ☐ No ☐ Which and for how long : _____

Glucorticoids Yes ☐ No ☐ Which and for how long : _____

Eltroxin Yes ☐ No ☐ Which and for how long : _____

Contraceptive Pill Yes ☐ No ☐ Which and for how long : _____

Hormone Replacement Therapy Yes ☐ No ☐ If yes, what: _____

Are you on any other medication? Yes ☐ No ☐

If yes, What? _____

_____

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