Bone Mineral Density Questionnaire – Under 21 Female/Male

THIS QUESTIONNAIRE CONSISTS OF *FOUR* PAGES. PLEASE ANSWER ALL QUESTIONS.

DATE: _____/_____/YYYY

PATIENT DETAILS - SECTION ONE

NAME: _____

DATE OF BIRTH: _____/_____/_____

SEX: MALE _____ FEMALE: _____

HEIGHT: _____ **WEIGHT:** _____

ADDRESS: _____

TELEPHONE NO: _____ **MOBILE:** _____

DOCTOR'S NAME: _____

OCCUPATION: _____

WHY ARE YOU HAVING A DEXA SCAN? _____

_____

SOCIAL STATUS: MEDICAL CARD HOLDER? _____ NON-MEDICAL CARD HOLDER? _____

MARITAL STATUS: _____ **HAVE YOU HAD ANY CHILDREN?** YES _____ NO _____

FULL TERM: _____ *MIS-CARRIAGE:* _____

SPONTANEOUS ABORTION: _____ *STILLBIRTH:* _____

EXERCISE HISTORY – SECTION TWO

EXERCISE HISTORY – NOW: TYPE: _____

MINUTES PER SESSION: _____ TIMES PER WEEK:

_____

EXERCISE HISTORY – IN THE PAST: TYPE: _____

MINUTES PER SESSION: _____ TIMES PER WEEK:

_____

ARE YOU, OR WHERE YOU EVER A COMPETITIVE ATHLETE? YES _____ NO _____

IF YES, AT WHAT LEVEL: _____

DO YOU REQUIRE DENTAL TREATMENT? _____

DIETARY HISTORY – SECTION THREE

ARE YOU ANY OF THE FOLLOWING?:

VEGETARIAN _____ *VEGAN* _____

IF YES, FOR HOW LONG? _____ **AT WHAT AGE DID YOU START?** _____

WAS YOU CHILDHOOD DIET: EXCELLENT _____ GOOD _____ AVERAGE _____ BAD _____
(Please tick).

DO YOU HAVE MILK IN YOU DIET? YES _____ NO _____

IF YES, TOTAL CONSUMPTION OF MILK PER DAY? _____ GLASSES

IF YES, WHAT TYPE OF MILK IS IT? SUPERMILK _____ REGULAR _____ LOW FAT _____ SOYA _____ OTHER _____

IS THERE CHEESE IN YOUR DIET? YES _____ NO _____

IF YES, TOTAL CONSUMPTION OF CHEESE PER WEEK? _____

IS THERE YOGURT IN YOUR DIET? YES _____ NO _____

IF, YES - TOTAL CONSUMPTION OF YOGURT PER WEEK? _____

DO YOU EAT ALL FOODS? YES _____ NO _____

IF NO, WHAT FOOD DO YOU NOT EAT? _____

DO YOU HAVE A HISTORY OF EATING DISORDERS? YES _____ NO_____

IF YES; *ANOREXIA:* YES _____ NO _____ *BULIMIA*: YES _____ NO _____

FREQUENT DIETING: YES _____ NO _____

IF YES; WHAT AGE DID YOU START? _____

HOW MUCH COFFEE DO YOU DRINK? INSTANT: _____ CUPS PER DAY. PERCOLATED: _____ CUPS PER DAY.

HOW MUCH TEA DO YOU DRINK? _____ CUPS PER DAY.

IF YES, AT WHAT STRENGTH: WEAK _____ STRONG ____

HOW MUCH WATER DO YOU DRINK? _____ GLASSES PER DAY.

HOW MUCH ALCOHOL DO YOU DRINK? _____ UNITS PER WEEK.

DO YOU SMOKE? YES _____ NO _____ PREVIOUS SMOKER _____

IF YES, WHAT AGE DID YOU START SMOKING? _____ **WHAT AGE DID YOU STOP?** _____
(Re previous smoker)

HOW LONG DID YOU SMOKE FOR? _____ **HOW MANY CIGARETTES PER DAY?** _____

MENSTRUAL HISTORY – SECTION FOUR

WHAT AGE DID YOU HAVE YOUR FIRST PERIOD: _____

HOW LONG WAS/IS YOUR CYCLE FROM THE BEGINNING OF ONE PERIOD TO THE NEXT? _____ (DAYS).

ARE YOUR PERIODS ALWAYS REGULAR? YES _____ NO _____

IF NO, HOW LONG IS YOUR CYCLE? _____

DO OR, DID YOU SUFFER FROM P.M.T.? YES _____ NO _____

DO OR, DID YOU SUFFER FROM AMENORRHOEA (NO PERIODS AND NOT PREGNANT)? YES _____ NO _____

IF SO, FOR HOW LONG DID YOU SUFFER FROM AMENORRHOEA? _____

MEDICAL HISTORY – SECTION FIVE

DO YOU SUFFER FROM ANY OF THE FOLLOWING? PLEASE TICK THE BOX.

VARICOSE VEINS:	YES _____ NO _____	**TYROID DISEASE:**	YES _____ NO _____
PHLEBITIS:	YES _____ NO _____	**HIGH CHOLESTEROL:**	YES _____ NO _____
DEEP VEIN THROMBOSIS:	YES _____ NO _____	**BLOATING:**	YES _____ NO _____
CANCER:	YES _____ NO _____	**CONSTIPATION:**	YES _____ NO _____
TYPE _____		**DIARRHOEA:**	YES _____ NO _____
RADIATION:	YES _____ NO _____	**MALABSORPTION:**	YES _____ NO _____
CHEMOTHERAPY:	YES _____ NO _____	**COELIAC:**	YES _____ NO _____
RHEUMATOID ARTHRITIS:	YES _____ NO _____	**HIATUS HERNIA:**	YES _____ NO _____
OSTEOARTHRITIS:	YES _____ NO _____	**GASTERIC ULCER:**	YES _____ NO _____
BLOOD DISEASES:	YES _____ NO _____	**LIVER DISEASE:**	YES _____ NO _____
TYPE: _____		**KIDNEY DISEASE:**	YES _____ NO _____
HAEMACHROMATOSIS:	YES _____ NO _____	**HYPOGONADISM:**	YES _____ NO _____
MIGRAINE:	YES _____ NO _____		
HYPERTENSION:	YES _____ NO _____	**TRANSPLANT:**	YES _____ NO _____
ASTHMA:	YES _____ NO _____	**DEPRESISON:**	YES _____ NO _____
KIDNEY STONES	YES _____ NO _____	**EPILEPSY:**	YES _____ NO _____
DIABETES:	YES _____ NO _____	**STROKE:**	YES _____ NO _____
TYPE: _____			

MEDICAL HISTORY, Continued.

HAVE YOU EVER SUFFERED FROM EXCESSIVE STRESS? YES _____ NO _____

HAVE YOU EVER HAD SURGERY? YES _____ NO _____

IF YES, WHAT TYPE OF SURGERY AND WHAT YEAR? _____ / _____

HAVE YOU EVER HAD A SERIOUS ILLNESS? YES _____ NO _____

IF YES, WHAT TYPE AND WHAT 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 ANY OTHER BONE DISORDER? YES _____ NO _____

DO YOU HAVE A PERSONAL HISTORY OF OSTEOPOROSIS? YES _____ NO _____

OR, OSTEOPENIA? YES _____ NO _____

HAVE YOU EVER SUSTAINED ANY FRACTURES (BROKEN A BONE)? YES _____ NO _____

IF YES, WHAT BONES? _____ **WHAT YEAR?** _____

DO YOU SUFER FROM LOW TRAUMA? YES _____ NO _____

HAVE YOU HAD A BAD FALL RECENTLY? YES _____ NO _____

IF SO PLEASE GIVE DETAILS; _____

HAVE YOU RECENTLY LOST WEIGHT? YES _____ NO _____

HAVE YOU RECENTLY HAD OR DO YOU HAVE ANY BACK PAIN? YES _____ NO _____

HAVE YOU HAD A TESTES REMOVED? YES _____ NO _____

HAVE YOU HAD MUMPS AFTER PUBERTY? YES ____ NO ____

HAVE YOU HAD LOSS OF LIBIDO? YES _____ NO _____

NO INTEREST IN SEX? _____

DO YOU HAVE A FAMILY HISTORY OF PROSTATE CANCER? YES _____ NO _____

MEDICATION – SECTION SIX

ARE YOU, OR HAVE YOU BEEN ON ANY OF THE FOLOWING MEDICATIONS OR VITAMINS?

CALCIUM AND VITAMIN D YES _____ NO _____

IF YES, FOR HOW LONG?

_____

_____

ARE YOU CURRENTLY ON ANY MEDICATION? YES _____ NO _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY ON?

_____

_____

_____

CONTRACEPTIVE PILL: YES _____ NO _____

IF YES, WHAT NAME AND FOR HOW LONG? _____

HORMONE REPLACEMENT THERAPY: YES _____ NO _____

IF, YES, PLEASE GIVE DETAILS

_____