LINDGREN
functional medicine

Bone Density Questionnaire

First Name: _____ Last Name: _____

DOB: _____ Prior DXA Scan Location & Date: _____

What is the tallest height you have ever been measured at*: (in inches)* _____

Ethnicity and race play a role in your personal risk for fracture, please check the race you most closely identify with:

- ☐ Caucasian/White
- ☐ African American/Black
- ☐ *Asian (this includes Indian, Pakistani & Bangladeshi)*
- ☐ Hispanic/Latino

☐ Yes ☐ No Is there a chance that you are pregnant?
☐ Yes ☐ No Have you had a barium X-ray in the last 2 weeks?
☐ Yes ☐ No Have you had an injection of an X-ray dye in the last week?
☐ Yes ☐ No Have you taken calcium or a multi-vitamin within 4 hours of this appointment?
☐ Yes ☐ No Have you had a hip replacement? ☐ Right ☐ Left ☐ Both
☐ Yes ☐ No Have you ever fractured *(broken)* any bones as an adult?
Which bones? _____ How? _____
☐ Yes ☐ No Did your mother or father break or fracture a hip at any age?
☐ Mother ☐ Father ☐ Both What age? _____
☐ Yes ☐ No Are you a current or former smoker?
How many cigarettes per day _____/ at your heaviest __ / how many years? _____
☐ Yes ☐ No On average do you drink three or more alcoholic beverages per day?
☐ Yes ☐ No Do you participate in any weight bearing exercise? If so, what kind? _____
☐ Yes ☐ No Do you fall? How often? _____
How many servings of dairy products do you intake daily? _____

Have you ever been diagnosed with any of the following conditions?

☐ Osteoarthritis	☐ Bowel/Celiac Disease	☐ Thyroid Disease
☐ Rheumatoid Arthritis	☐ Vitamin D Deficiency	☐ Parathyroid Disease
☐ Lupus	☐ Cushing's Disease	☐ Kidney Disease
☐ Back Pain	☐ Heart Disease	☐ Paget's Disease
☐ Asthma or Emphysema	☐ Atrial Fibrillation	☐ Dental Work/Oral Surgery
☐ Chronic Malnutrition	☐ Malabsorption	☐ Chronic Liver Disease
☐ Insulin Dependent Diabetes *(Type 1)*		☐ Osteogenesis Imperfecta
☐ Long-standing untreated overactive thyroid *(hyperthyroidism)*		☐ Low Testosterone or Hypogonadism

If you answered yes to any of these conditions, please elaborate:

_____
_____
_____
_____
_____

Have you taken any of the following medications over the last two years? *(If yes, indicate dates below.)*

☐ Yes ☐ No Fosamax (Alendronate) Dates: _____
☐ Yes ☐ No Actonel (Risedronate) Dates: _____
☐ Yes ☐ No Boniva (Ibandronate) Dates: _____

☐ Yes ☐ No ReClast (Zoledronate Acid) Dates: _____
☐ Yes ☐ No Zometa (Zoledronic Acid) Dates: _____

Have you taken any of the following medications over the last one year? (If yes, indicate dates below.)

☐ Yes ☐ No Estrogen pills/patches, hormone replacement pills or patches
Dates: _____
☐ Yes ☐ No Evista (Raloxifene) Dates: _____
☐ Yes ☐ No Calcitonin/Miacalcin nasal spray Dates: _____
☐ Yes ☐ No Forteo (Teriparatide) by injection (shots) Dates: _____
☐ Yes ☐ No Tymlos (Abaloparatide) by injection (shots) Dates: _____
☐ Yes ☐ No Prolia (Denosumab) by injection (shots) Dates: _____
☐ Yes ☐ No Evenity (Romosozumab) by injection (shots) Dates: _____

Have you ever taken any of the following medications? *(If yes, indicate dates below)*

☐ Yes ☐ No Anti-Seizure Drugs:
Dilantin (Phenytoin), Tegretol (Carbamazepine), Depakote (Valproic acid) or Phenobarbital
Dates: _____
☐ Yes ☐ No Hormone Blocking Drugs:
Arimidex (Anastrozole), Femara (Letrozole), Lupron (Leuprolide), or Aromasin (Exemestane)
Dates: _____
☐ Yes ☐ No Anticoagulants Dates: _____
☐ Yes ☐ No Calcitonin Dates: _____
☐ Yes ☐ No Diuretics Dates: _____
☐ Yes ☐ No Calcium Supplements *(including TUMS or antacids)*
Dates: _____

☐ Yes ☐ No Vitamin D Supplements Dates: _____
☐ Yes ☐ No Steroids: Prednisone, Hydrocortisone, Dexamethasone
Dates: _____
☐ Yes ☐ No Methotrexate Dates: _____

Women Only

☐ Yes ☐ No Have you missed more than six months of menstrual periods before menopause, not due to pregnancy?
☐ Yes ☐ No Have you gone through menopause *(no periods for 1 year or more)?*
Your age at last period? _____
☐ Yes ☐ No Have you had *both* your ovaries removed? If so, at what age?_____