

CIF.50

**BONE DENSITY QUESTIONNAIRE**  
**YOU MUST BRING THIS FORM COMPLETED TO YOUR APPOINTMENT**

|                      |  |            |       |
|----------------------|--|------------|-------|
| <b>Name</b>          |  |            |       |
| <b>Date of Birth</b> |  | <b>Age</b> | years |
| <b>Address</b>       |  |            |       |

| CR No    |   | GP Practice          |                                     |
|----------|---|----------------------|-------------------------------------|
| Referral |   | Referrer             |                                     |
| 1.       | Are you physically active,<br>Do you do strength and balance exercise?                                      | Yes / No<br>Yes / No |                                     |
| 2.       | Do you spend 30mins or more a day outside?  | Yes / No             |                                     |
| 3.       | Do you smoke?   | Yes / No             |                                     |
| 4.       | Have you ever smoked in the last 15 years?  | Yes / No             |                                     |
| 5.       | Do you have more than 2 units of alcohol per day or 14 units week?  | Yes / No             |                                     |
| 6.       | Do you have a calcium rich diet? (i.e., have milk, cheese, yoghurts etc)                                    | Yes / No             |                                     |
| 7.       | Have you broken any bones following a trip and fall?<br>Which bone did you break and how old were you?      | Yes / No             |                                     |
| 8.       | Did either of your parents break their hip?   | Yes / No             |                                     |
| 9.       | Have you ever had a low body weight? i.e., BMI below 21   | Yes / No             |                                     |
| 10.      | Do you suffer from any medical conditions?  | Yes / No             |                                     |
| 11.      | Are you on any medication?  | Yes / No             |                                     |
| 12.      | Original Height                      Current Height   |                      | Weight                              |
|          | <b>IF YOU HAVE LOST 5CMS OR MORE PLEASE CALL 01872 252290 or email rcht.bonedensitometryqueries@nhs.net</b> |                      | <b>AS YOU MAY NEED EXTRA SCANS.</b> |

|     |   |                  |  |
|-----|---|------------------|--|
| 13  | Any acid reflux, gastric ulcer or hiatus hernia   | Yes / No         |  |
| 14  | Do you have any dental issues?  | Yes / No         |  |
|     | Are you currently registered with a Dentist?  | Yes / No         |  |
|     | Have you <b>ever</b> taken any of these medications   |                  |  |
| 15  | Prednisolone (oral steroids)  | Yes / No         |  |
|     | Have you ever had drug treatment for cancer?  | Yes / No         |  |
|     | Calcium   | Yes / No         |  |
|     | Vitamin D   | Yes / No         |  |
| 16. | Have you <b>ever</b> had treatment for Osteoporosis?<br>e.g., Alendronate, Risedronate, Actonel, Fosamax,<br>Strontium Ranelate, Raloxifene, Zoledronate, Denosumab | Yes / No         |  |
|     |   |                  |  |
| 17. | How many falls have you had in the last 12 months?  |                  |  |
| 18  | Have you been seen in a falls clinic?   |                  |  |
| 19  | What age did you start your menstrual cycle   | Age / NA         |  |
| 20  | Are you having a natural menstrual cycle  | Yes / No<br>/ NA |  |
| 21  | When was your last period   | Age / NA         |  |
| 22  | If you have taken HRT, at what age and for how long?  |                  |  |
| 23  | Have you had a hysterectomy   | Yes / No         |  |
| 24  | Did your menstrual cycle stop for more than 6 months<br>(excluding pregnancy or menopause)  | Yes / No         |  |

|  |                                |
|--|--------------------------------|
| <b>I can confirm I have no reason to believe I am or may be pregnant</b> | <b>Patient Signature</b>       |
|  | <b>Radiographers Signature</b> |
|  | <b>Date</b>                    |

**PLEASE BRING THIS COMPLETED QUESTIONNAIRE WITH YOU FOR YOUR APPOINTMENT AND ANY MEDICATION.**

|                      |            |             |             |  |
|----------------------|------------|-------------|-------------|--|
| Doc ID.              | Version No | Pages       | Authored by | <b>Original Document &amp; Audit Trail Held on<br/>Q Pulse</b> |
| CI.DEXA.<br>FORMS.02 | 09         | Page 2 of 2 | Penny Lewis |  |