Shared health Soins communs Manitoba

Bone Density and J. P. Maclean Osteoporosis Centre
St. Boniface General Hospital
408 - 400 Tache Avenue, Winnipeg, MB R2H 3C3
Phone (204) 237-2756 FAX (204) 237-4195

Department of Nuclear Medicine / Bone Density
Diagnostic Imaging / Brandon Regional Health Centre
G149 - 150 McTavish Ave E., Brandon, MB R7A 2B3
Phone (204) 578-4325 FAX (204) 578-4986

TO BE COMPLETED BY THE PATIENT.

Please take a few minutes to complete this questionnaire. This information will be used to provide your doctor with a more complete interpretation of the bone density test, since test results need to be considered with other risk factors for osteoporosis (brittle bones).

If you answer YES to any of the following, please *phone* the receptionist immediately:

Is there any chance that you are *pregnant*?
Have you had a barium x-ray in the last *2 weeks*?
Have you had a nuclear medicine scan or x-ray dye in the *last week*?

1. a) Please list all prescription medications that you take regularly, starting with osteoporosis medications (including estrogen hormones).	1._____ 2._____ 3._____ 4._____ 5._____ 6._____ 7._____ 8._____
b) Are you currently taking any prescription medication for osteoporosis? Since when?	○Yes ○No
c) Have you previously taken any prescription medication for osteoporosis? Which medication? When did you start and stop?	○Yes ○No
2. Please list any major health conditions diagnosed by a doctor and that need regular treatment.	
3. Have you ever had an operation on your: If yes, what type of operation?	Right Hip or Leg ○ Yes ○No Left Hip or Leg ○ Yes ○ No Spine or Lower Back ○Yes ○No
4. Have you ever had a bone density test before? If Yes, please indicate where.	○Yes ○No Done at:
5. Have you had any back x-rays in the last year? If Yes, please indicate where.	○Yes ○No Done at:
6. What is your major ethnic origin? (Your answer may affect your test results.)	○White ○ Black ○Aboriginal ○Asian-Oriental ○Asian-Indian ○Other (Specify):
7. Have you had a menstrual period in the last year unrelated to medication (women only)? ○Yes ○ No	Age of last menstrual period:_____ Hysterectomy? ○Yes ○No Ovaries removed? ○Yes ○No

Continued on reverse side…

Your printed name _____ **Today's Date** _____

TO BE COMPLETED BY THE PATIENT.

1. Have you broken/fractured any bones shown by x-ray after age 40? (Include spine "crush" or "compression" fractures.) ○ Yes ○ No

   What bone(s) did you break? _____/_____

   How and when did you break it? _____/_____

   Where was the x ray done? _____/_____

2. Did either of your parents have surgery for a fractured/broken hip after age 50? (Do NOT include hip replacements for arthritis.)

   ○ Yes (Mother) ○ Yes (Father) ○ No ○ Don't know

3. Are you currently a smoker?

   ○ Yes ○ No

4. In a typical week, how many average size drinks with alcohol do you have?

   _____ ○ None

5. Has a doctor diagnosed and treated you for rheumatoid arthritis? (Do NOT include other kinds of arthritis like osteoarthritis.)

   ○ Yes ○ No ○ Don't know

6. In the last year have you taken an oral steroid medication (such as prednisone)?

   ○ Yes ○ No ○ Don't know

   If yes, in the past 12 months for how many weeks total did you take this steroid medication and what was your average daily dose?

7. Have you fallen in the last year? (Do NOT include minor slips or from sports.)

   ○ Yes. How many times? _____ ○ No ○ Don't know

FOR STAFF USE ONLY

Measured height (stadiometer): _____ inches Estimated

Measured weight: _____ lbs Estimated

MD use Fracture: Average-risk High-risk Alcohol≥3 units/d

Steroid dose: Low(≤2.5) Moderate High(>7.5) Secondary osteoporosis