Trinitas Diagnostic Imaging
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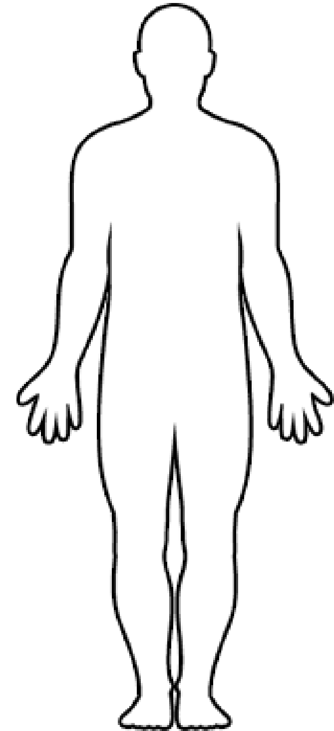
www.TrinitasDiagnosticImaging.com

Osteoporosis Questionnaire

If you're coming to our center for this test, print this page, fill out the form and bring it in with you on the day of your appointment.



Please circle the portion of your body that is in pain.

FIRST NAME

LAST NAME

AGE DATE OF BIRTH

SEX ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER: - -

ADDRESS

CITY

STATE

ZIP

HOME PHONE - -

WEIGHT HEIGHT TALLEST HEIGHT

ARE YOU LEFT -OR- RIGHT HANDED? ☐ LEFT ☐ RIGHT

* WHAT AGE DID YOU HAVE YOUR FIRST PERIOD?

* WHAT AGE DID YOU HAVE YOUR LAST PERIOD?

ARE YOU TAKING HORMONES? ☐ YES ☐ NO

IF YES, WHAT TYPE ?

* DID YOU EVER HAVE A HYSTERECTOMY? ☐ YES ☐ NO

* ARE YOU ALLERGIC TO ANY MEDICATION? ☐ YES ☐ NO

IF YES, WHAT TYPE ?

* DID YOU EVER BREAK ANY BONES IN THE PAST? ☐ YES ☐ NO

IF YES, WHICH ONES?

NAME OF PHYSICIAN ORDERING PROCEDURE?

* IF APPLICABLE