Austin Health

DEPARTMENT OF MOLECULAR IMAGING AND THERAPY
Telephone: (03) 9496 2611
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Heidelberg Repatriation Hospital,
Level 2 Centaur Wing South,
300 Waterdale Road
PO Box 5444
Heidelberg West
Victoria Australia 3081

Not for Retention in SMR

BONE DENSITY PATIENT QUESTIONNAIRE

Date _____ Appointment Time: _____

Patient Details

Surname _____ Home Phone Number _____

First Name(s): _____ Mobile Phone Number _____

Date of Birth: _____ Medicare/Vet Affairs Number _____

Address: _____ Pension or Heath Care Card ☐ Yes ☐ No

Suburb _____ Post Code _____ Sex ☐ Male ☐ Female

Please answer all of the following questions if applicable by ✓ticking the appropriate answer.
If you have any questions, the Technologist will assist you.

1. **Have you had a previous bone density scan?** ☐ Yes ☐ No

   If yes, was this at Austin Health ☐ Yes ☐ No

Have you ever broken any bone? ☐ No ☐ Yes, if yes which ones?

Bone Broken	Age when broken	Details of how it was broken
For example: Lt Radius (Forearm)	*65*	*Tripped on a rug*

2. **Have either of your parents ever fractured a hip ?**

   ☐ Mother: (Age when fracture _____years) ☐ Father: (Age when fracture _____years)

3. **Do you have any of these conditions, if yes ✓**

   ☐ Osteoporosis ☐ Bowel Disease (e.g. malabsorption) ☐ Kidney Disease
   ☐ Thyroid Disease ☐ Asthma (steroid inhaler or tablet) ☐ Rheumatoid Arthritis
   ☐ Hyperparathyroidism ☐ Liver Disease ☐ Multiple Myeloma

4. **Are you currently receiving or have you previously received steroids?:**

   e.g. Prednisolone, Dexamethasone, Hydrocortisone, Cortisone

   ☐ No YES ☐ Previously or ☐ Currently

   if Yes, Dosage …….mg or ……..... tablets each day Length of treatment……..

5. **Current Medication: please ✓ if you take any listed**

   ☐ Calcium/Caltrate ☐ Vitamin D ☐ Fosamax ☐ Actonel ☐ Protos (Strontium)
   ☐ Prolia (Denosumab) ☐ Aclasta (Zolodronic Acid) ☐ Teriparatide (PTH) ☐ Steroid Inhaler
   ☐ Hormone Replacement Therapy (e.g. hormone patches, Provera etc.). Length of Time……

6. **Have any of these treatments ✓ticked changed in the last year?** ☐ **No** ☐ **Yes**

7. **Do you smoke?** ☐ **No** ☐ **Yes: for how many years** ----------

8. **Do you consume more than 3 units of alcohol per day** ☐ **No** ☐ **Yes**

9. **Have you had a Nuclear Medicine Scan, or an X-ray involving a drink or injection this last week?**

   ☐ **Yes** ☐ **No**

Female patients, please turn page for further questions. Turn Page

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FEMALE PATIENTS **please** complete

Patient Details

Surname _____ **First Name(s)** _____

Address _____

Suburb _____ **Post Code** _____

Date of Birth _____

Are you pregnant? ☐ Yes ☐ No

Have you reached menopause? ☐ No ☐ Yes If Yes, how old were you? _____

Have you had a hysterectomy? ☐ No ☐ Yes If Yes, how old were you? _____

If yes you have had a hysterectomy, were both ovaries removed ☐ Yes ☐ No

OR only one ovary removed ☐ Yes ☐ No

OR ☐ I Don't Know

Did your periods ever stop for more than 6 months before you were 45 years old and; not pregnant or breastfeeding?

☐ Yes ☐ No

Signature _____

FOR STAFF OFFICE USE ONLY **Date** _____/_____/20_____

Patient Category

☐ **PRP (Private)** **Doctor:** _____

☐ **Specialist Clinics** **Clinic:** _____

☐ **Other** _____

Were the scans sent with the patient? ☐ **Yes** ☐ **No**

Copies of Scans to : _____

_____

_____

Form of Payment: ☐ **No Charge** ☐ **Medicare** _____ ☐ **Payment** _____