

Questionnaire bone density measurement



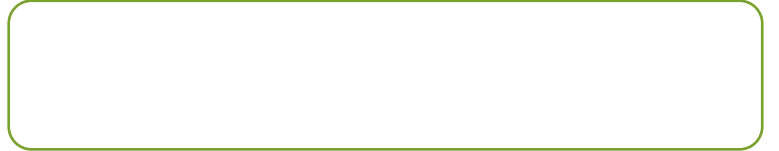
Dear Sir/Madam,

You are coming to or are having a bone density measurement at UZ Leuven. To additionally assess your fracture risk as best as possible, please carefully complete this questionnaire. You can also ask a family member or relative to complete the questionnaire for you.

The information in this questionnaire gives us an idea of your fracture history, treatments and risk factors. This information is obviously confidential.

If you have questions or comments about this questionnaire please ask one of the care providers. Could we please ask you to complete this questionnaire as soon as possible and return it to the staff member performing the bone density measurement?

Thank you for your co-operation.



Questionnaire bone density measurement

FRACTURE HISTORY

- Have you suffered a bone fracture in the past 24 months?
 - Yes
 - No

- If yes, was this a fracture of
 - pelvis
 - hip
 - femur
 - vertebra/vertebral column
 - shoulder
 - forearm/wrist
 - other, namely:

- If you sustained a fracture, how did you sustain it?
 - Without a fall/spontaneous
 - After a fall from a standing height or out of bed
Briefly describe your fall:
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 - As a result of a high-impact accident (e.g. fall while cycling, car accident, fall from a ladder ...)
Briefly describe your fall:
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.....
 - Other cause:
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TREATMENT OF BONE DECALCIFICATION/OSTEOPOROSIS

- Are you on medication for the treatment of osteoporosis?
 - No
 - Yes (*multiple answers possible*)
 - Calcium supplement
 - Calcium and vitamin D supplement
 - Alendronate/Fosamax[®] (weekly tablet)
 - Risedronate/Actonel[®] (weekly tablet)
 - Ibandronate/Bonviva[®] (monthly tablet or injection)
 - Zoledronate/Aclasta[®] (infusion 1x/year)
 - Zoledronate/Zometa[®] (infusion)
 - Denosumab/Prolia[®] (injection 2x/year)
How long have you been receiving this medication (in years)?
 - Romosozumab/Evenity[®] (2 syringes 1x/month)
 - Raloxifene/Evista[®] (daily tablet)
 - Teriparatide/Forsteo[®] (daily injection)

RISK FACTORS

- How tall are you (*in cm*)?
- How much do you weigh (*in kg*)?
- Do you smoke?
 - Yes
 - No
- Do you drink 3 or more units of alcohol per day?
 - Yes
 - No
- Have either of your parents ever suffered a hip fracture?
 - Yes
 - No
- Do you suffer from rheumatoid arthritis (an autoimmune disease)?
 - Yes
 - No
- Have you used steroids/cortisone for ≥ 3 months in the past year or are you currently using steroids/cortisone (e.g. Medrol[®], prednisone)?
 - Yes
 - No

COMMENTS OR QUESTIONS

Do you have any additional comments or questions? Write them down here.

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Thank you for your co-operation.

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