

Bone Density Risk Factor Information

NAME: _____ DATE OF BIRTH: _____ AGE: _____

GENDER: _____ HEIGHT: _____ WEIGHT: _____

ETHNICITY: Caucasian Black American Indian Asian Hispanic
 Other: _____

PRIOR DEXA EXAMS? Yes No
 If yes, when: _____ Where? _____

PATIENT RISK FACTORS:

- | | | |
|---|------------------------------|-----------------------------|
| Family history of osteoporosis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| History of hyperparathyroidism or high serum calcium? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you currently smoke? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| History of prior fragility fracture? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| History of oral steroid use? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcohol intake greater than or equal to 3 drinks per day? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you take vitamin D? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you take calcium? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you take medication for osteoporosis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If yes, name of drug: _____

Chronic diseases? Gastrointestinal Endocrine Renal Liver Immobility Rheumatoid Arthritis

Prior surgeries? Lumbar spine? Yes No
 Hip? Yes No If yes, right left both

Have you had Barium or a Nuclear Medicine study in the past 10 days? Yes No

FEMALE PATIENTS:

Menopause? Yes No If yes, at what age: _____
 Have you had a hysterectomy? Yes No If yes, were the ovaries removed? _____
 Do you take Estrogen? Yes No If yes, for how many years? _____

COMMENTS: _____

MEDICATIONS: _____

Signature of Patient: _____ Date: _____

Tech Initials: _____

