

## BONE DENSITOMETRY PATIENT INFORMATION

Name \_\_\_\_\_ DOB \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Date \_\_\_\_\_  

Last
First
MI

Have you had a barium or Nuclear Medicine study in the last 2 weeks?  Yes  No  
 Have you had hyperparathyroidism or a high calcium level in your blood?  Yes  No

**Female Patients only:**

Is there a chance that you are pregnant?  Yes  No

***If you answered yes to any of the above, speak to our receptionist right away***

1. Age: \_\_\_\_\_ Sex:  Male  Female

**2. Ethnicity:**

Caucasian (white)  Black  American Indian  Asian  Hispanic  Other

3. Have you ever had a bone density test?  Yes  No

If YES, when and where? \_\_\_\_\_

4. Have you had a recent weight change?  Yes  No

If YES, tell us about it: \_\_\_\_\_

5. Have you lost over 2 inches in height since age 20?  Yes  No

**6. Have you ever broken a bone?**

| Bone Broken | Simple Fall? | If not a simple fall, please describe the circumstances | Age this occurred |
|-------------|--------------|---|-------------------|
|             |              |   |                   |
|             |              |   |                   |
|             |              |   |                   |
|             |              |   |                   |

7. Do you have a personal history of osteoporosis?  Yes  No

8. Do you have a family history of osteoporosis?  Yes  No

9. Do you have a personal history of cancer?  Yes  No

If YES, please describe: \_\_\_\_\_

10. Do you have a personal history of anorexia/bulimia?  Yes  No

**11. Have you ever had surgery of the spine, hips, legs or arms?**

| Part of body | Affected side | Type of surgery |
|--------------|---------------|-----------------|
|              |               |                 |
|              |               |                 |
|              |               |                 |
|              |               |                 |

**12. Are you currently receiving or have you previously received prednisone pills (cortisone)?**

Yes, currently  Yes, previously  No

If yes, for how long? \_\_\_\_\_ What is/was your dose? \_\_\_\_\_ mg. or \_\_\_\_\_ pills each day.

***(Please continue on other side)***

13. List any chronic medical conditions that you have:

|  |
|--|
|  |
|  |

14. Are you currently receiving or have you previously received any of the following medications?

| <i>Description</i>                               | <i>Yes</i> | <i>No</i> | <i>For how long?</i> |
|--|------------|-----------|----------------------|
| Medication for seizures                          |            |           |                      |
| Chemotherapy for cancer                          |            |           |                      |
| Medication to prevent organ transplant rejection |            |           |                      |
| Medication for thyroid disease                   |            |           |                      |
| (Men only) Medication for prostate cancer        |            |           |                      |

15. Have you been treated with the following medications?

| <i>Medication</i>                      | <i>Ever?</i> | <i>Currently?</i> | <i>If current, how long?</i> |
|--|--------------|-------------------|------------------------------|
| Hormone replacement therapy (Estrogen) |              |                   |                              |
| Tamoxifen                              |              |                   |                              |
| Raloxifene (Evista)                    |              |                   |                              |
| Testosterone                           |              |                   |                              |
| Etidronate (Didronel/Didrocal)         |              |                   |                              |
| Alendronate (Fosamax)                  |              |                   |                              |
| Risedronate (Actonel)                  |              |                   |                              |
| Intravenous pamidronate (Aredia)       |              |                   |                              |
| Clondronate (Bonfos, Ostac)            |              |                   |                              |
| Calcitonin (Miacalcin nasal spray)     |              |                   |                              |
| PTH (Forteo)                           |              |                   |                              |
| Zoledronic acid (Zometa)               |              |                   |                              |
| Sodium fluoride (Fluotic)              |              |                   |                              |
| Boniva                                 |              |                   |                              |
| Reclast                                |              |                   |                              |

16. How many servings of the following do you eat/drink each day (on average)?

|                               | <b>Milk<br/>(full cup)</b> | <b>Orange juice fortified<br/>with calcium (full cup)</b> | <b>Yogurt (small<br/>container or ½ cup)</b> | <b>Cheese</b> |
|-------------------------------|----------------------------|---|--|---------------|
| <b>Number of<br/>servings</b> |                            |   |  |               |

17. Do you take any calcium supplements (including TUMS)?  Yes  No

18. Do you take any vitamin D supplements (including multivitamins and halibut liver oil)?  Yes  No

19. Do you smoke?  Yes  No

*For women only...*

20. Are you still having menstrual periods?  Yes  No

21. Before menopause, have you ever missed your periods for 6 months or more, besides during pregnancy?  Yes  No

22. Have you had menopause?  Yes  No  
If YES, at what age? \_\_\_\_\_

23. Have you had a hysterectomy?  Yes  No  
If YES, at what age? \_\_\_\_\_

24. Have you had both of your ovaries removed?  Yes  No  
If YES, at what age? \_\_\_\_\_

