Facility Name: _____
Address: _____
City, State ZIP: _____

BONE DENSITY PATIENT HISTORY

Effective Date: May 1, 2018

PATIENT DEMOGRAPHICS

Patient Name: _____ Medical Record #: _____

Date of Exam: _____ Referring Dr.: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ ☐ Male ☐ Female

Ethnicity: ☐ Caucasian ☐ Hispanic ☐ Asian ☐ African American ☐ Native American ☐ _____

Reason for Exam: _____

MEDICAL HISTORY

☐ Yes ☐ No Have you ever had a bone density scan? When / Where? _____

☐ Yes ☐ No Have you had back or hip surgery? When / What type? _____

☐ Yes ☐ No Have you had a hip fracture? When? / Which hip? _____

☐ Yes ☐ No Has an x-ray of your spine shown abnormality(s) suggesting osteoporosis, osteopenia or fracture?

☐ Yes ☐ No Have you had any fractures during you adult life that did not result from significant trauma?

☐ Yes ☐ No Did either of your parents ever have a hip fracture?

☐ Yes ☐ No Do you / Did you smoke? ☐ Yes ☐ No Drink 3 or more alcoholic drinks / day?

☐ Yes ☐ No Do you regularly consume dairy products? ☐ Yes ☐ No Do you drink caffeinated beverages?

☐ Yes ☐ No Do you have secondary osteoporosis? ☐ Yes ☐ No Do you have rheumatoid arthritis?

☐ Yes ☐ No Do you perform weight bearing exercise regularly?

☐ Yes ☐ No What was your maximum height? _____ (In inches): _____

☐ Yes ☐ No Have you had any contrast studies in the past 2 weeks? What exam? _____

MEDICATIONS – Check any of the following that you have ever taken

☐ Prescription for osteoporosis? How long? _____ ☐ Prednisone/ Steroids? How long? _____

☐ Glucocorticoids	☐ Miacalcin (calcitonin)	☐ Protelos (strontium ranelate)	☐ Calcium
☐ Actonel (risedronate)	☐ Reclast (zoledronate)	☐ Forteo (parathyroid hormone)	☐ Vitamin D
☐ Evista (raloxifene)	☐ Boniva (ibandronate)	☐ HRTI (estrogen/hormone therapy	☐ Thyroid Meds
☐ Fosamax (alendronate)	☐ Prolia (denosumab	☐ Other: _____	

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS – Check any that apply

☐ Anorexia or Bulimia	☐ Hyperparathyroidism	☐ Cancer
☐ Asthma or Emphysema	☐ Any Seizure Disorder	☐ Other: _____
☐ End Stage Renal Disease	☐ Inflammatory Bowel Disease	

IF FEMALE

☐ Yes ☐ No Any chance you are pregnant? Date Last Menstrual Period: _____

At what age did you start your period? _____

☐ Yes ☐ No Are you premenopausal? ☐ Yes ☐ No Postmenopausal? Approx age of menopause: _____

☐ Yes ☐ No Have you had a hysterectomy? ☐ Partial ☐ Complete At what age or what year? _____

☐ Yes ☐ No Are you taking or have you ever taken hormone replacement therapy? How long? _____

☐ Yes ☐ No Do you currently have night sweats? ☐ Yes ☐ No Hot flashes?

STAFF TO COMPLETE THIS SECTION: CLINICAL INDICATIONS – Check all that apply

☐ Cushing's Syndrome	☐ History of Osteoporosis	☐ Gonadal Dysgenesis (Turner's Syndrome)
☐ Hyperparathyroidism	☐ History of Osteopenia	☐ On Osteoporosis Therapy (Ex: Fosamax)
☐ Premenopausal Woman	☐ History of Vertebral Fracture	☐ Long Term use of high risk medications
☐ Post Menopausal Woman	☐ Calcium supplements	☐ Female on hormone replacement therapy