

BONE DENSITY MEDICAL HISTORY

Please read carefully. Complete FRONT & BACK in its ENTIRETY

Name: _____ Height: _____ Weight: _____ lbs. Age: _____ yrs.

Race: White Sex: Female Are you? Right Handed
 Black Male Left Handed
 Hispanic
 Asian
 Other _____

Have you had a DEXA Bone Mineral Density exam before? Yes No
 If yes, when and where: _____

Is this exam for: Osteoporosis Screening
 Monitoring Osteoporosis Treatment
 Other: _____

MENOPAUSE

(Female Patients Only)

YES NO

		Are you postmenopausal (Have you stopped having a period?)
		Do you have any postmenopausal symptoms? If YES – Explain: _____ If NO: Having no current problems/currently in asymptomatic postmenopausal state.
		Have you had a hysterectomy?
		Did you have both of your ovaries removed?
		Is there a chance you could be pregnant?

OSTEOPOROSIS RISK FACTORS

YES NO

		Do you drink three or more alcoholic drinks every day?
		Do you have a family history of Osteoporosis?
		Has either of your parents fractured their hip without major trauma?
		Do you take steroids regularly (≥5 mg of prednisone per day for at least 3 months)
		Do you have a history of fracture; hip, spine, shoulder or forearm without trauma
		Do you have a history of any of the following (If YES , check all that apply)
		<input type="checkbox"/> Diabetes Type 1 <input type="checkbox"/> Premature menopause (< 45) <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Crohn's, Ulcerative colitis <input type="checkbox"/> Hypogonadism <input type="checkbox"/> Chronic antiseizure medication <input type="checkbox"/> Breast Cancer Chemotherapy
		Have you been diagnosed with Rheumatoid Arthritis?
		Do you currently smoke tobacco?
		Have you lost two inches or more in height since high school?



BONE DENSITY MEDICAL HISTORY OSTEOPOROSIS

YES NO

		Have you been diagnosed with Osteoporosis or Osteopenia? <i>IF YES</i> , please circle which one												
		Are you being medically treated for Osteoporosis or Osteopenia (other than Calcium or Vitamin D)? <i>IF YES</i> , which medication(s) are you taking and for how long?												
		<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Fosamax, Fosamax plus D, Dinosto _____</td> <td><input type="checkbox"/> Boniva _____</td> </tr> <tr> <td><input type="checkbox"/> Actonel, Atelvia _____</td> <td><input type="checkbox"/> Forteo _____</td> </tr> <tr> <td><input type="checkbox"/> Miacalcin, Fortical, Calcitonin _____</td> <td><input type="checkbox"/> Evista _____</td> </tr> <tr> <td><input type="checkbox"/> Reclast, Zometa _____</td> <td><input type="checkbox"/> Prolia _____</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Estrogen or Hormone Replacement Therapy (list) _____</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Other: _____</td> </tr> </table>	<input type="checkbox"/> Fosamax, Fosamax plus D, Dinosto _____	<input type="checkbox"/> Boniva _____	<input type="checkbox"/> Actonel, Atelvia _____	<input type="checkbox"/> Forteo _____	<input type="checkbox"/> Miacalcin, Fortical, Calcitonin _____	<input type="checkbox"/> Evista _____	<input type="checkbox"/> Reclast, Zometa _____	<input type="checkbox"/> Prolia _____	<input type="checkbox"/> Estrogen or Hormone Replacement Therapy (list) _____		<input type="checkbox"/> Other: _____	
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OTHER INFORMATION

 Do you have a removable continuous glucose-monitoring device? Yes No

 Have you had ORAL contrast for a CT or X-ray procedure in the past 7 days? Yes No

Have you had prior surgery to your: (check all that apply)

 Right Hip Left Hip Lumbar Spine Right Wrist Left Wrist

ADDITIONAL NOTES

I have read and completed the above questions on the Bone Density Medical History form. I have been provided the opportunity to ask any questions I may have. I verify this by signing below.

 Patient or Authorized Representative

 Date

 If not patient, relationship to patient

FOR TECHNOLOGIST USE ONLY

By signing below, I acknowledge the following:

1. I have reviewed the above information on Bone Density Medical History form with the patient in its entirety.
2. I provided the patient an opportunity to ask any questions he/she may have.

Reviewed by/Signature: _____ Bone Density Technologist Date: _____