Bone Densitometry: Patient History Form

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NEW MEXICO CLINICAL RESEARCH & OSTEOPOROSIS CENTER, INC.

Patient Name ________________________________ Today's Date ____________________

Who ordered this bone density test? ____

Shall we send copies of your report to anyone else? ____________________________________

What is the reason for doing this bone density test?_____________________________________

Have you had a bone density test before? _________ When and where? ______________

____

Age ______ Sex ______ What was your height at age 25? _______ Weight at age 25? ________

Ethnic Group: Caucasian ❐ Hispanic ❐ Asian ❐ African-American ❐ Other ______

Osteoporosis Risk Factor Assessment

	Yes	No
Are you a postmenopausal woman?	❐	❐
Have you lost more than 2 in. height?	❐	❐
Have you broken bones since age 40?	❐	❐
Does your mother or father have osteoporosis?	❐	❐
Has your mother or father had a broken hip?	❐	❐
Do you smoke cigarettes?	❐	❐
Have you ever had surgery of the spine, hip, or forearm?	❐	❐
Do you weigh less than 127 lbs?	❐	❐
Have you ever taken steroids, such as prednisone, for more than 3 months?	❐	❐
Are you now taking prednisone?	❐	❐
Have you been on chemotherapy?	❐	❐
Do you have kidney failure?	❐	❐
Do you have rheumatoid arthritis?	❐	❐

	Yes	No
Do you take anticonvulsant medication, like Dilantin, phenobarb, or Tegretol?	❐	❐
Have you ever had hyperthyroidism (an overactive thyroid gland)?	❐	❐
Have you had hyperparathyroidism, or a high calcium level in your blood?	❐	❐
Do you have inflammatory bowel disease, such as Crohn's disease?	❐	❐
Do you have malabsorption problems, such as celiac disease?	❐	❐
Have you had stomach surgery, such as gastrectomy or stapling?	❐	❐
Have you had an eating disorder?	❐	❐
Have you had an organ transplant?	❐	❐
Do you have a paralyzed arm or leg?	❐	❐
Do you have 3 or more alcohol drinks per day?	❐	❐

If you answered yes to any of these questions, please give details below:

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Medication	Dose (# pills or mg.)	Date Started	Date Stopped	Reason Stopped
Calcium				
Calcium with Vitamin D				
Multivitamin				
Vitamin D				
Estrogen Pill or Patch				
Estrogen Cream				
Testosterone				
Fosamax (alendronate)				
Actonel (risedronate)				
Evista (raloxifene)				
Miacalcin (calcitonin)				
Forteo (teriparatide)				
Boniva (ibandronate)				
Reclast (zoledronic acid)				
Aredia (pamidronate)				
Didronel (etidronate)				
Strontium				
Prednisone				

Comments and Other Medications: ____

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May we contact you for possible participation in research studies? Yes ❐ No ❐

For women only:

At what age was your last period? ______________________

Have you ever missed periods, besides during pregnancy? _______

Have you ever had phlebitis or blood clots? ______________

Have you had cancer of the breast, ovary, uterus, or cervix? ______

For men only:

Do you have erectile dysfunction (impotence)? ___________

Do you have low testosterone? ______________________

Have you had prostate cancer? ______________________

Are you receiving medication for prostate cancer? ______________

Notes

Medical history reviewed and patient counseled on skeletal health issues.

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