

Bone Densitometry: Patient History Form

Revised 12/10

NEW MEXICO CLINICAL RESEARCH & OSTEOPOROSIS CENTER, INC.

Patient Name _____ Today's Date _____

Who ordered this bone density test? _____

Who is your current primary care provider? _____

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 | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Are you a postmenopausal woman? | <input type="checkbox"/> | <input type="checkbox"/> | Do you take anticonvulsant medication, like Dilantin, phenobarb, or Tegretol? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you lost more than 2 in. height? | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had hyperthyroidism (an overactive thyroid gland)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you broken bones since age 40? | <input type="checkbox"/> | <input type="checkbox"/> | Have you had hyperparathyroidism, or a high calcium level in your blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your mother or father have osteoporosis? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have inflammatory bowel disease, such as Crohn's disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your mother or father had a broken hip? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have malabsorption problems, such as celiac disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you smoke cigarettes? | <input type="checkbox"/> | <input type="checkbox"/> | Have you had stomach surgery, such as gastrectomy or stapling? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery of the spine, hip, or forearm? | <input type="checkbox"/> | <input type="checkbox"/> | Have you had an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you weigh less than 127 lbs? | <input type="checkbox"/> | <input type="checkbox"/> | Have you had an organ transplant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever taken steroids, such as prednisone, for more than 3 months? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have a paralyzed arm or leg? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you now taking prednisone? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have 3 or more alcohol drinks per day? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been on chemotherapy? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Do you have kidney failure? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Do you have rheumatoid arthritis? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

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

| Medication for Osteoporosis | Dose (# pills or mg.) | Date Started | Date Stopped | Reason Stopped |
|----------------------------------|-----------------------|--------------|--------------|----------------|
| Calcium | | | | |
| Calcium with Vitamin D | | | | |
| Multivitamin | | | | |
| Vitamin D | | | | |
| Estrogen (pill or patch) | | | | |
| Testosterone | | | | |
| Fosamax (alendronate) | | | | |
| Actonel, Atelvia (risedronate) | | | | |
| Evista (raloxifene) | | | | |
| Miacalcin, Fortical (calcitonin) | | | | |
| Forteo (teriparatide) | | | | |
| Boniva (ibandronate) | | | | |
| Reclast (zoledronic acid) | | | | |
| Prolia (denosumab) | | | | |
| Aredia (pamidronate) | | | | |
| Didronel (etidronate) | | | | |
| Strontium | | | | |
| Other | | | | |

Comments and Other Medications: _____

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? _____

| <u>Notes</u> |
|---|
| <p>Medical history reviewed and patient counseled on skeletal health issues.</p> <p>_____</p> |