Bone Densitometry

MRN: ______________________ Appointment Time: _______________ Date: _______________
PPO: ______________________ Self Pay: ______________________ w/IVA: _______________
Mammogram: _____________ Ultrasound: ______________________

Name: ____ Age: ____________________ Birthdate: ______________

Height: _______________ Weight: _______________ When was your last height measured? ______________

Ethnicity: ☐ Caucasian ☐ African – American ☐ Hispanic ☐ Asian ☐ Other

Referring Physician: __________________________ Other Physicians to get copy of report? ___________________

Family history of osteoporosis? ☐ Yes ☐ No Who? __________________________

Have you had this exam before at another institution? ☐ Yes ☐ No Where? ______________________________

Are your menses regular? ☐ Yes ☐ No

Have you complete menopause? ☐ Yes ☐ No ☐ Maybe If so, at what age? ____________________

Hysterectomy? ☐ Yes ☐ No If yes, at what age? _______

☐ Both ovaries removed ☐ One ovary is left ☐ don't know

Currently taking estrogen? ☐ Yes ☐ No

If yes, ☐ Vaginal Cream/Suppositories ☐ Evista ☐ Birth Control Pills
☐ Estrogen Skin Patch ☐ Vaginal Ring ☐ Sequential Pills
☐ Progesterone ☐ Biodentical Hormones ☐ Continuous Pills

If No, did you previously take estrogen? ☐ Yes ☐ No If yes, when did you stop? ______ years ago.

Do you have/Have you had any of the following:

☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Glaucoma ☐ Anemia ☐ Breast Cancer
☐ Gastrointestinal Problems ☐ Thyroid/Parathyroid Disease ☐ Asthma ☐ Diabetes
☐ Renal Failure ☐ Connective Tissue Disease ☐ Lupus ☐ Osteoarthritis
☐ Current or past history of eating disorders (Anorexia, Bulimia, Laxative Abuse)

Do you take any of the following?

☐ Fosamax ☐ Actonel ☐ Aromour Thryoid ☐ Prednisone ☐ Immunosuppressives ☐ Plavix
☐ Forteo injections ☐ Boniva ☐ Synthroid ☐ Inhaled Steroids ☐ Tamoxifen ☐ Calcitonin
☐ Prolia Infusions ☐ Activella ☐ Cytomel ☐ Coumadin ☐ Arimidex ☐ Vitamin D ☐ Reclast Infusions

Calcium Supplements: ☐ Never ☐ Occasionally ☐ Every day ☐ More than once a day

Other medication you take: ____

Have you had any fractures in the past four years? ☐ Yes ☐ No Where _______________ When ____________

Have you had surgery on spine or any joint replacements? ☐ Yes ☐ No Where __________ When __________