BONE DENSITOMETRY HISTORY SHEET

Name: _____ Date: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Sex: ( ) Male ( ) Female
For females only, are you menopausal? . . . . . ( ) No ( ) Yes
If yes, at what age? _____

Ethnicity: ( ) Caucasian ( ) Asian ( ) African American ( ) Hispanic ( ) Other

Imaging History

Previous DEXA scan? . . . . . ( ) No ( ) Yes
If yes, when_____ where _____

Have you had a contrast study in the last 2 weeks? . . . . . ( ) No ( ) Yes
(CT with oral contrast, Fluoroscopy, Bone Scan, Barium Enema, ect.)

Surgical History

Previous Hip Surgery . . . . . ( ) No ( ) Yes
Previous Spine Fracture . . . . . ( ) No ( ) Yes
Previous Back Surgery (with metal hardware or vertebroplastry) . . . . . ( ) No ( ) Yes

Risk Factors

Previous Fractures . . . . . ( ) No ( ) Yes
Parent Hip Fracture. . . . . ( ) No ( ) Yes
Current Smoker . . . . . ( ) No ( ) Yes
Glucocorticoids . . . . . ( ) No ( ) Yes
Rheumatoid Arthritis . . . . . ( ) No ( ) Yes
Alcohol intake (3 or more drinks / day) . . . . . ( ) No ( ) Yes
Secondary Osteoporosis—Do you have any of the following:
(Hyperparathyroidism, Diabetes, Liver Disease, Lung Disease, Malnutrition
Anorexia/bulimia Inflammation, Premature Menopause). . . . . ( ) No ( ) Yes

Osteoporosis Treatment History:

Are you **currently** taking any of the following bone density medications?
(Fosamax, Evista, Actonel, Forteo, Miacalcin, Boniva, Reclast, ect). . . . . ( ) No ( ) Yes
If yes, how long? _____ date stopped?_____