FACILITY:_____

_____

_____

_____

**History Form**

**FORM.POL.002**
**Effective Date: November 23, 2009**

BONE DENSITY PATIENT HISTORY

## BONE DENSITY PATIENT HISTORY

Name: _____ Date:_____

Date of Birth: _____ ☐Male ☐ Female Age: _____

Weight: _____lbs. Height: _____ft._____in

Ethnicity:

☐ Caucasian ☐ Hispanic ☐ Asian ☐ African American ☐ Native American

1. ☐ YES ☐ NO Have you had a prior bone density scan? Yes / No
   Where: _____When:_____
2. ☐ YES ☐ NO Do you take prescription medication for osteoporosis? How long? _____
3. ☐ YES ☐ NO Do you take a calcium supplement
4. ☐ YES ☐ NO Do you take prednisone or other steroids? How Long? _____
5. ☐ YES ☐ NO Do you take Thyroid Meds? How Long? _____ Type_____
6. ☐ YES ☐ NO Have you had any recent (past 2 weeks), contrast studies, i.e. barium enema, UGI, IVP, etc. What exam? _____
   Referring Physician: _____
7. ☐ YES ☐ NO Have you had back surgery? Yes / No
8. ☐ YES ☐ NO Have you had hip surgery? Yes / No Right or Left

**FEMALES ONLY**

1. Approximate age of menopause: _____
2. ☐ YES ☐ NO Have you had a hysterectomy?
   ☐ Partial ☐ Complete
3. Year or age at time of hysterectomy: _____
4. ☐ YES ☐ NO Are you taking hormone replacement therapy? How long? _____
5. ☐ YES ☐ NO Have you ever taken hormone replacement therapy? How long? _____
6. ☐ YES ☐ NO Do you currently have night sweats?
   ☐ Occasionally ☐ Seldom
7. ☐ YES ☐ NO Do you currently have hot flashes?
   ☐ Occasionally ☐ Seldom

**INDICATIONS FOR DEXA REPORTS**

___ Cushing's Syndrome
___ Gonadal Dysgenesis (Turner's Syndrome)
___ Premenopausal Woman
___ Post Menopausal Woman
___ History of Osteoporosis
___ History of Osteopenia
___ Female currently on hormone replacement therapy
___ Long Term use of high risk medications
___ Current therapy for Osteoporosis (e.g.: FOSAMAX)
___ Hyperparathyroidism
___ History of Vertebral Fracture
___ Calcium supplements? Type_____