

PATIENT HISTORY for OSTEOPOROSIS SCANNING

Please answer the following questions. If you are not sure how to answer a question, leave the space blank, and we will assist you with the answer.

Name: _____ Date of Birth: _____

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Home Address: _____ City, State Zip : _____

Weight: _____ Height Measured: _____ Previous Height: _____

Race: African American Asian Caucasian Hispanic Other: _____

Referring Physician: _____

1. Have you fractured any bones during your adult life? YES or

NO

2. Does your family have a history of osteoporosis? YES or NO

3. Do you smoke more than half a pack of cigarettes per day? YES or NO

4. Do you smoke currently? YES or NO

5. Have you smoked in the past? YES or

NO

6. Do you have more than three or more servings of dairy products everyday? YES or NO

(one serving = 8 oz. milk, 1.5 oz cheese, 8 oz yogurt, 8 oz cottage cheese, 4 oz ice cream)

7. Have you consumed three or more dairy servings per day throughout most of your life? YES or

NO

8. Have you ever been treated for osteoporosis or weak bones? YES or

NO

If so, what was the treatment? _____

9. Do you take a calcium supplement daily? YES or NO

If so, how much? 0 - 500 mg/day 501 - 1000 mg/day >1000 mg/day

Do you take a Vitamin D supplement? YES or NO

If so, how much?

10. Do you exercise at least three times per week? YES or NO

11. Do you drink more than two alcoholic beverages per day? YES or NO

12. Have you taken any of the following medications or treatments?

NO
or NO

Steroids (prednisone, cortisone, etc) YES or
Thyroid medication YES

NO

Anticonvulsants (for seizures, epilepsy) YES or

NO

Loop diuretics (Lasix, Burnex, Edicrin) YES or

NO

Heparin YES or NO
Chemotherapy YES or

NO

Lithium YES or

NO

13. Have you had any of the following conditions?

NO

Hyperthyroidism or Hyperparathyroidism YES or

or NO

Biliary cirrhosis YES

Kidney disease YES

or NO

Rheumatoid arthritis
Other arthritis
Part of stomach removed

YES or NO
YES or NO
YES

or NO

Intestinal or bowel disease

YES or NO

Eating disorders (anorexia nervosa, bulimia, etc.) YES or

NO

14. Do you have back pain?

YES or NO

15. Have you gone through menopause?

YES or NO

16. Did your menopause occur before age 45?

YES or

NO

17. Are you currently taking hormone replacement medication?

YES or

NO

18. Is this your first bone densitometry?

YES or

No