

BONE DENSITY MEDICAL HISTORY

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Weight:** _____ **Height:** _____

- Yes No Have you had any test in the past week that required contrast (oral or Injection)?
 Yes No Have you had any loss in height? If yes, how much? _____
 Yes No Have you had any recent (within 5 years) fractures of the spine, hip, pelvis or long bone?
 Yes No Have you ever had hip or spine surgery?
 Yes No Do you have a family history of Osteoporosis?
 Yes No Do you have hyperparathyroidism or a high calcium level in your blood?
 Yes No Are you on thyroid medications? (Synthroid, Thyroxin, etc)
 Yes No Are you on a Corticosteroid therapy? (Prednisone, Cortisone, etc)
 Yes No Do you have a personal history of cancer? If yes, type: _____
 Yes No Did you have chemotherapy treatment?
 Yes No Do you take calcium supplements? Have you taken any in the last 24 hours? Yes No
 Yes No Have you ever smoked cigarettes? If yes, how long? _____

Have you been or currently being treated with the following medications?

MEDICATION	EVER	CURRENTLY	HOW LONG
Hormone replacement therapy			
Tamoxifen			
Evista			
Fosamax			
Actonel			
Boniva			
Aromasin			
Arimidex			
Aredia			
Maicalcin nasal spray			
Forteo			
Zometa			
Femara			

For women only...

- Yes No Have you gone through menopause? If yes, at what age? _____
 Yes No Did you have premature menopause due to ovarian removal or ovarian failure? If yes, at what age? _____