



Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Patient Acct# \_\_\_\_\_ Sex  M  F Date of Birth \_\_\_\_\_

Current Height \_\_\_\_\_ Weight \_\_\_\_\_ Referring Physician \_\_\_\_\_

When was your last Bone Density study? \_\_\_\_\_ Ethnicity \_\_\_\_\_

Please answer **Yes or No**

**Yes No**

1. Have you had any fractures during your adult life? \_\_\_\_\_

2. Did either of your parents ever have a hip fracture? \_\_\_\_\_

3. Do you smoke? \_\_\_\_\_

4. Have you ever taken  Glucocorticoids or  steroid therapy? \_\_\_\_\_

5. Do you have  rheumatoid arthritis or  Auto Immune disorder? \_\_\_\_\_

6. Do you have secondary osteoporosis? \_\_\_\_\_

7. Do you drink 3 or more alcoholic drinks per day? \_\_\_\_\_

8. Do you have a family history of Osteoporosis? \_\_\_\_\_

**Have you ever taken any of the following medications?**

**Yes No**

Actonel \_\_\_\_\_  
dose

Evista \_\_\_\_\_  
dose

Miacalcin \_\_\_\_\_  
dose

Reclast \_\_\_\_\_  
dose

Other \_\_\_\_\_  
dose

**Yes No**

Actonel \_\_\_\_\_  
dose

Forteo \_\_\_\_\_  
dose

Vitamin D \_\_\_\_\_  
dose

Hormone Replacement Therapy

\_\_\_\_\_  
dose

**Do you have any of the following medical conditions?**

- Anorexia or Bulimia       Any seizure disorders       End stage renal disease       Cancer
- Asthma or Emphysema       Inflammatory bowel disease       Hyperparathyroidism       Hysterectomy

What was your maximum height? \_\_\_\_\_

Do you perform weight-bearing exercise regularly? \_\_\_\_\_

Do you consume dairy products regularly?  Yes  No

Do you drink caffeinated beverages?  Yes  No

**For Women Only**

Do you think you might be pregnant?  Yes  No

Are you still menstruating?  Yes  No If no, at what age did you go through menopause? \_\_\_\_\_

Have you had a hysterectomy?  Yes  No  Partial  Complete If yes, what year? \_\_\_\_\_

Were your ovaries removed?  Yes  No Are you currently taking hormone pills?  Yes  No