

CC:

Patient History:

HISTORY:

X-RAY # _____
Dx Code (s) _____

Height _____
Weight _____

Please complete the following questions to the best of your ability. If you are unsure how to answer, leave the space blank and the Technologist performing your exam will help you. All answers will be kept in strict confidence and treated as information in your medical record.

(Please Print)

1. Your name _____

2. Street address _____

City _____ State _____ Zip _____

Date of Birth _____ Phone # _____

3. Referring physician _____

4. Afro-American White Asian Hispanic Other

5. Male Female Yes No

6. Any family history of osteoporosis?

7. Have you ever had a bone density study before?

8. Have you ever had surgery on your lower back?

9. Have you ever had surgery on your hips?

10. Have you fractured/broken any bones during your adult life?

11. Do you smoke at the present time?

12. Have you smoked in the past? If so, for how long? _____

13. How many servings of dairy products do you consume per day? _____

(Example: One serving=8 oz. milk, 1 oz cheese, container of yogurt, or serving of ice cream)

14. Have you consumed three or more dairy servings per day?

(as defined above) most of your life?

15. Do you take a calcium supplement daily?

If so, how much? And for how long? _____

0-500 mg/day 501-1000 mg/day >1000 mg/day

16. Are you involved in an exercise program at least three times per week?

17. Do you drink more than two alcoholic drinks per day?

Continue to other side.....

Radiologist's Signature _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| 18. Have you taken any of the following medicine? | | |
| a. Steroids (prednisone, cortisone, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Thyroid medication | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Anticonvulsants (for seizures, epilepsy) | <input type="checkbox"/> | <input type="checkbox"/> |
| d. How long have you taken or did you take the above medication_____years. | | |
| 19. Have you had any of the following conditions? | | |
| a. Partial or complete paralysis | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Medical condition involving the thyroid | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Medical condition involving the parathyroid | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Part of your stomach removed | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Intestinal or bowel disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Are you now on any bone enhancement medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| Examples: Fosamax, Actonel, Evista, Boniva, Miacalcin(calcitonin), etc. | | |
| If so, how long?_____years. | | |

Remaining Questions for Females Only

- | | Yes | No |
|--|--------------------------|--------------------------|
| 21. Any chance of pregnancy? Sign_____ date_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you gone through menopause (change of life)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Did your menopause occur before age 45? If so, age_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you have amenorrhea (never started periods or ended at a young age)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you take hormones (Premarin, estrogens, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you taken hormones (not including birth control pills) in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. How long have you taken or did you take hormones?_____years. | | |
| 28. Have you had any of the following conditions? | | |
| a. Hysterectomy (uterus removed) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Ovaries removed | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Breast Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, are you on any medication? | | |
| Examples: Tamoxifen, Femara, Arimidex, Aromiacin, etc. | | |
| Please specify_____ | | |