Diagnostic Radiology Center of the Treasure Coast

Bone Densitometry Patient History

Please complete the following questions to the best of your ability. If you are unsure how to answer, skip it and we will help with the answer when you are seen.

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NAME _____DOB ____/____/_____

REFERRING PHYSICIAN _____

HEIGHT _____ INCHES WEIGHT _____POUNDS

1. **RACE:** AFRO-AMERICAN CAUCASIAN NATIVE AMERICAN ORIENTAL OTHER

2. **SEX:** FEMALE MALE

3. HAVE YOU FRACTURED ANY BONES DURING YOUR ADULT LIFE? **YES NO**
   IF SO, WHAT BONE? _____

4. IS THERE A ***FAMILY*** *HISTORY* OF OSTEOPOROSIS? **YES NO**
5. DO YOU SMOKE MORE THAN HALF A PACK OF CIGARETTES PER DAY? **YES NO**
6. HAVE YOU SMOKED IN THE PAST? IF SO, HOW LONG?_____ **YES NO**

7. DO YOU CONSUME DAIRY PRODUCTS DAILY? **YES NO**
8. HAVE YOU CONSUMED THREE OR MORE DAIRY SERVINGS PER DAY FOR MOST OF YOUR LIFE? **YES NO**

9 DO YOU TAKE A CALCIUM SUPPLEMENT DAILY? **YES NO**
IF SO, HOW MUCH?
[ ] 0-500MG/DAY [ ] 501-1000MG/DAY [ ] > 1000MG/DAY

10. DO YOU EXERCISE AT LEAST THREE TIMES PER WEEK? **YES NO**

11. DO YOU DRINK MORE THAN TWO ALCOHOLIC DRINKS PER DAY? **YES NO**

12. HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS? **YES NO**
    [ ] STEROIDS (PREDNISONE, CORTISONE, ETC.)
    [ ] THYROID MEDICATION
    [ ] ANTICONVULSANT (FOR SEIZURES, EPILEPSY)

13. ARE YOU TAKING ANY BONE MINERAL REPLACEMENTS, SUCH AS FOSIMAX, EVISTA, OR MYACALCIN? **YES NO**

14. HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS? **YES** **NO**

[ ] PARTIAL OR COMPLETE PARALYSIS
[ ] HYPERTHYROIDISM (OVER-ACTIVE THYROID)
[ ] KIDNEY DISEASE
[ ] RHEUMATOID ARTHRITIS
[ ] OTHER ARTHRITIS
[ ] PARTOFTHE STOMACH REMOVED
[ ] INTESTINAL OR BOWEL DISEASE

********** **REMAINING QUESTIONS FOR FEMALES ONLY** **********

15. HAVE YOU GONE THROUGH MENOPAUSE (CHANGE OF LIFE)? **YES** **NO**

16. DID YOUR MENOPAUSE OCCUR BEFORE AGE 45? **YES** **NO**

17. DO YOU NOW TAKE HORMONES (PREMARIN, ESTROGENS, ETC.)? **YES** **NO**

18. HAVE YOU TAKEN HORMONES, IN THE PAST? **YES** **NO**
(NOT INCLUDING BIRTH CONTROL PILLS)

19. IF SO, HOW LONG DID YOU TAKE HORMONES? _____

20. HAVE YOU HAD ANY OF THE FOLLOWING SIDE EFFECTS FROM HORMONES? **YES** **NO**

[ ] BREAST SORENESS
[ ] HEAVEY PERIODS OR OTHER BLEEDING
[ ] HEADACHES
[ ] WEIGHT GAIN OR FLUID BUILDUP
[ ] OTHER

21. DO YOU HAVE AMENORRHEA, NEVER STARTED PERIODS OR ENDED AT A YOUNG AGE? **YES** **NO**

22. HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS? **YES** **NO**

[ ] HYSTERECTOMY (WOMB REMOVED)
[ ] OVARIES REMOVED
[ ] BLOOD CLOTS (WERE YOU ON HORMONES AT THE TIME?) **YES** **NO**
[ ] BREAST CANCER
[ ] FAMILY HISTORY OF BREAST CANCER
[ ] CANCER OF THE UTERUS (WOMB)