Patient History

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 when you are seen at our facility. All answers will be kept in strict confidence and treated as medical record information.

1.Name ____

2.Date of Birth ______________

3.Height ________________

4.Weight ________________

5.Race
African American ___ Asian ___ Caucasian ___ Hispanic ___
Native American ___ Other ___

6.Sex Female ___ Male ___

7.Have you had a previous Bone Density test (DEXA)? Yes ___ No ___
When __________________ Where ________________

8.Are you now or have you ever been treated for osteoporosis? Yes___ No___
Specify drug(s):________________ Dose:________________
Date of use:___________________________________

9.Referring Physician ____________________________

10.Have you fractured any bones during your lifetime?
a) Spine _____ Date ______
b) Hip _______ Date ______
c) Other ______ Date ______

11. Have you had any of the following surgery?
a) Laminectomy / Fusion (lumbar spine) Date __________
b)Abdominal Surgery Date __________
c) Hip Surgery:
Fracture (right/left) Date __________
Prosthesis (Right/Left) Date __________
Hardware (ORIF) (Right/Left) Date __________
d) Thyroid /Parathyroid surgery Date __________

12. Does your family have a history of osteoporosis? Yes ___ No ____

13.Do you smoke more than half a pack of cigarettes per day? Yes __ No __

14.Have you smoked in the past? Yes ___ No ___ Packs per Day ______

15.Do you have 3 or more servings of dairy products every day?
(One Serving= 8 oz. Milk, 1.5 0z. cheese, 8 oz. Yogurt, 8 oz. Cottage cheese, or 4 oz. Ice cream) Yes ____ No ____

16. Do you take a calcium supplement daily? If so, how much?
0-500 mg/day _____ 501-1000 mg/day _____ >1000 mg/day _____

17. Do you take Fosamax? Yes________ No________ In the past___________
If so, how much ___________; how long ________________________

18.Do you exercise at least three times a week? Yes ____ No _____

19.Do you drink more than two alcoholic beverages per day? Yes ___No___

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

a) Steroids (prednisone, cortisone, etc.) Yes____ No ____
If yes, why___________; dose_______; how long_______________

b) Thyroid medication Yes ____ No ____

c) Anticonvulsants (for seizures, epilepsy) Yes ____ No ____

d) Loop diuretics (Lasix, Bumex, Edicrin) Yes ____ No ____

e) Heparin Yes ____ No ____

f) Chemotherapy Yes ____ No ____

g) Lithium Yes ____ No ____

h) Birth Control Pills Yes ____ No ____

i) Hormone Replacement Therapy Yes_____No ____

j) Antacids Yes ____ No____

k) Vitamins Yes ____ No ____

21. Have you had any of the following conditions?

a) Hyperthyroidism or hypothyroidism Yes____ No____

b) Hyperparathyroidism Yes ____No ____

b) Biliary Cirrhosis Yes ____ No ____

c) Kidney Disease Yes ____ No ____

d) Rheumatoid Arthritis Yes ____ No ____

e) Other arthritis Yes ____ No ____

f) Part of stomach removed Yes ____ No ____
g) Intestinal or bowel disease Yes ____ No ____
h) Eating Disorders (anorexia nervosa, bulimia, etc.)
Yes ____ No ____
i) Scoliosis Yes ____ No ____
j) Liver disease Yes ____ No ____
k) Seizure disorder Yes ____ No ____
l) Increased calcium Yes ____ No ____

22. Have you had any of the following radiographic tests?
a) Myelogram Date ________
b) Cat Scan w/contrast Date ________
c)Barium study Date ________
d) X-rays of spine Date ________
e) X-rays of Hips Date ________
f) Nuclear Medicine Study:
Scan Date ________
Treatment w/ radioactive Material
Date ________
Test w/ radioactive material
Date ________

Remaining Questions For Women Only

23. Is there any possibility that you are pregnant? Yes____ No____
24. Have you gone through menopause? Yes____ No ____
If yes, when____________________
25. Did your menopause occur before age 45? Yes ____ No ____
If yes, what age____________________
26. Have you ever had amenorrhea (missed periods or never started periods)? Yes ____ No ____
27. Have you ever taken hormones (not including birth control pills)?
If so, for how many years? __________ Yes ____ No ____
28. Have you had any of the following conditions?
a) Hysterectomy: (uterus removed) Yes ____ No ____
b) Ovaries removed Yes ____ No ____
If yes, when____________________
c) Breast Cancer Yes ____ No ____
d) Cancer of the uterus (womb) Yes____ No ____