BONE DENSITY
Women's Imaging Center

Name:_____
Date of Birth:_____**Sex: ___FEMALE ___MALE ___RACE**
Referring Provider:_____
Current Height:_____ **cm Weight:**_____**kg Tallest height ever:**_____
Reason for visit?_____

Primary Risk Factors	**YES**	**NO**
As an adult, have you had any broken bones (except skull, facial bones, hands and feet)? Which bones have you broken? Any broken bones after age 50?		
Have you fractured a hip, wrist, ankle, ribs or back bones from a fall from a standing height, or spontaneously without falling? Please circle bone fractured if YES.		
Do you currently smoke tobacco?		
Do you drink more than two alcohol containing drinks per day?		
Do you have Rheumatoid Arthritis that has been diagnosed by a physician?		
Is there a parental history of hip fracture?		
Are you currently on oral or intravenous steroids (Prednisone,Cortisone,Medrol,Solu-Medrol, Decadron, etc.)? Dose?		
Have you been on oral or intravenous steroids for longer than 3 months in the past? What was the dose?		
Do you regularly use nasal or inhaled steroid preparations?		
On average, how many servings of dairy products (milk, cheese, yogurt, ice-cream or calcium fortified orange juice) do you consume each day?		
Calcium and Vitamin D	**YES**	**NO**
Do you take a calcium supplement daily (including TUMS)? If YES, How much 500-600mg/day _____ 1000-1200mg/day _____ Over 1200mg/day _____		
Does your calcium supplement contain Vitamin D? If YES, how much?		
Do you take additional Vitamin D or a multivitamin? If YES, how much?		
Are you taking or have you taken any of the following medications? Avandia/Actos/Proton Pump Inhibitors Prilosec(Omeprazole)/Nexium/Protonix/Prevacid/Aciphex	**YES**	**NO**
Medications to prevent organ transplant rejection		
Anticonvulsants (for seizures, epilepsy)		
Chemotherapy for cancer		
Arimidex (Anastrozole), Aromasin(Exemestane),Femara(Letrozole) Lupron or Casodex		
***Do you have or have you had any of the following conditions*?**	**YES**	**NO**
Pituitary problems?		
Hyperthyroidism?		
Hyperparathyroidism?		
Diabetes Type 1 or Diabetes Type 2 PLEASE CIRCLE		
Intestinal or bowel disease such as lactose intolerance, Crohn's ,Celiac Sprue or Colitis		
Part of stomach removed or weight loss reduction (bariatric) surgery?		
An eating disorder including Anorexia or Bulimia?		
Lymphoma or Leukemia?		
Kidney failure, need for dialysis, renal transplant or kidney stones?		

History of falls, unsteady gait, visual or neurological problems which might increase your risk of falling?	**YES**	**NO**
COPD or Emphysema?		
Have you ever had spinal surgery?		
Difficulty standing and walking on your own?		
Do you exercise at least three times a week?		

Females Only	**YES**	**NO**
Have you gone through or are you going through Menopause (change of life)?		
Did your menopause occur before age 45?		
Are you currently using estrogen replacement hormones in the form of pills or patch (this does not include the use of estrogen cream)? **Age of first use_____** **Age of last use_____**		
Have you had a hysterectomy? If YES, at what age? _____?		
Were your ovaries removed? If YES, at what age? _____?		
Are you on Depo-Provera?		
Are you on Birth Control Pills?		

Are You Taking Antiresorptive or Bone Protecting Medication?

Medication	**Ever?**	**Currently?**	**If current, how long?**
Actonel (Risedronate), Atelvia or Fosamax (Alendronate)			
Boniva (Ibandronate)			
Didronel (Etidronate)			
Intravenous Aredia (Pamidronate)			
Reclast/Zometa(Zolendronic Acid)			
Estrogen Replacement (Pill or Patch)			
Evista (Raloxifene)			
Tamoxifen			
Testosterone Replacement(Injection, Gel or Patch)			
Forteo Injections (PTH)			
Miacalcin Nasal (Calcitonin)			
Denusomab/Prolia			

Males Only	**YES**	**NO**
Are you on hormonal therapy Lupron, Casodex, or Other_____ for prostate cancer? Please circle or write medication used.		
Are you on testosterone replacement in the form of injection, gel or patch?		

My signature confirms this information is correct_____