

First Name _____ Last Name _____ DOB/Age _____

Ht. _____ Wt. _____ Allergies _____ PT# (Internal) _____

Ethnicity/Nationality (For purpose of fracture risk calculation) _____

REASON FOR EXAM (Please include symptoms and time frame):

TECH NOTES (for internal use only):

Oral (i.e. Barium)/IV contrast or Nuc Med Test in the last 2 weeks? Yes No

Additional Tech Notes:

Previous Imaging/surgeries Related to Todays Exam	Date

Have you ever had a bone density test? Yes No If yes, when/where? _____

Bone fracture as an adult? Yes No If yes, location of fracture: _____ when? _____

Injury details: _____

Hip fracture in mother or father? Yes No If yes, age when fracture occurred: _____

Injury details: _____

Ever had surgery on your spine, hips, or arms? Yes No If yes, please specify location: _____

When? _____ Reason for surgery: _____

Uterus removed (Hysterectomy)? Yes No If yes, what age? _____

Ovaries Removed? Left Right Both No If yes, what age? _____

Have you gone through menopause? Yes No Not sure If yes, what age? _____

If no, date of last cycle: _____ If not sure, explain: _____

Previously diagnosed with Osteoporosis? Yes No If yes, when/where? _____

Previously diagnosed with Osteopenia? Yes No If yes, when/where? _____

Ever diagnosed with Secondary Osteoporosis? Yes No If yes, when? _____

Ever diagnosed with Rheumatoid Arthritis (not Osteoarthritis) Yes No If yes, when? _____

Are you a smoker? Yes No Do you consume 3 or more alcoholic drinks per day? Yes No

Are you taking any of the following medication(s) to treat Low Bone Density? (check all that apply):

Risedronate (Actonel) Alendronate (Fosamax) Zoledronic Acid (Reclast) Pamidronate (Aredia)

Etidronate (Didronel) Ibandronate (Boniva) Denosumab (Prolia) Other: _____

Are you taking Calcium/Vitamin D? Yes No If yes, how long? _____

Ever taken Estrogen/Testosterone or Hormone Replacement? Yes No If yes, please specify the following:

Type: _____ Dose: _____ How often: _____

Ever taken glucocorticoid pills (e.g. prednisone) > 3 months? Yes No If yes, please specify the following:

Type: _____ Dose: _____ How often: _____

I agree that the above information is correct (Do not fill out until after technologist has reviewed):

Patient Signature: _____ Today's Date: _____