Patient Focused • Quality Oriented • Physician Driven

Regional Arthritis & Osteoporosis Center

Specializing In Bone Density Testing and Osteoporosis

Name____ Date of Birth _____________ Age _______

Please answer the following questions:

Have you had a bone density test before? Yes___ No ___ When ________ Where ___________

Sex: Male _____ Female ______ Current weight: ________ Height __________

Fracture history: ____
(Please indicate fracture site and your age at time of fracture)

Ordering Physicians Name: ____

Medication : **Please circle if you are taking any of the following:**

Fosamax	Miacalcin	Calcium Supplement	Estrogen
Actonel	Evista	Vitamin D	Steroids (prednisone)
Forteo	Thiazide (water pill)	Thyroid Supplement	Alendronate
Reclast	Boniva	Boniva IV	If yes how long?_____

Other
Medications____

____

Have you had any of the following surgeries? Hip _____ Back _____ Thyroid______

Medical History: **Please circle if you have any of the following conditions:**
Hyperthyroid Epilepsy Diabetic Cushings Cancer Asthma Scoliosis Hyperparathyroid Rheumatoid Arthritis

Other medical conditions____

____

In the past 2 weeks have you had radiology testing involving dye or contrast materials? Yes____ No____

Have you taken calcium today? Yes____ No _____

Female Patients:
Are you pregnant? Yes____ No ____ Past Menopause: Yes _____ No _____ Age ______

Hysterectomy Yes ____ No _____ If yes, were both ovaries removed? Yes ____ No _____
At what age did you have the hysterectomy ?________

Signature ____Date _______________