AQ Modern Diagnostic Imaging

Bone Density History Sheet

Name:_____ Date: _____

Age: _____ Date of birth: _____ Weight: _____ Height:_____

Ethnic Background please circle: Caucasian African American Hispanic Asian Indian Other: _____

Have you ever had a bone density before? YES NO Date of Last study: _____

Where: _____ Date of last menstrual period: _____

Have you reached menopause? YES NO if yes, At what age: _____

1. Have you ever had a total or partial Hysterectomy? YES NO At what age: _____
   Why? _____
   Were your ovaries removed? YES NO
   Any family history of osteoporosis? YES NO
   Do you smoke? YES NO
   Do you drink alcohol? YES NO
   Do you exercise? YES NO
   Are you right handed? YES NO

2. Have you had a fracture or had surgery on:
   Spine: YES NO if yes, RIGHT or LEFT
   Hip: YES NO if yes, RIGHT or LEFT
   Forearm/wrist: YES NO if yes, RIGHT or LEFT
   Have you had other fractures? YES NO
   if yes, where: _____
   Have you lost 2 inches in HEIGHT in recent years? YES NO
   Have you had an xray/nuclear scans in the last 2 weeks?
   YES NO if yes, Specify:
   _____
   _____

3. Do you take estrogen, progesterone or any hormonal medications?
   YES NO

   Do you take any of the following medications? YES NO
   (Circle all that apply) Estrogen Fosamax Evista Miacalcin
   Calcium Prednisone/Steroid Thyroid Medication
   Seizure Medication for how Long: _____

4. Do you have any of the following:
   __Absence of menstrual before menopause
   __Diabetes Mellitus
   __Any thyroid condition? If yes, Hyper or Hype? _____
   __Hypertension
   __Testosterone deficiency
   __Anxiety/Depression
   __Cushing's syndrome or Gaucher's disease
   __Intestinal disease, Malabsorption
   __Liver or Kidney disease? Are you on Dialysis? YES NO
   List medications: _____

X_____ _____
Patients signature Date