

Patient History Form

Bone Density

Patient Name: _____

Age: _____ **Height:** _____ **Weight:** _____

Is this your first Bone Density Examination? Yes _____ No _____

If no, please indicate facility name and date of last examination: _____

Have you had any children? Yes _____ No _____

Do you smoke? Yes _____ No _____

Do you drink alcohol? Yes _____ No _____

Are you currently taking steroids? Yes _____ No _____

Are you currently taking medication for osteoporosis? Yes _____ No _____

Have you lost 2 inches (or more) in your height since high school? Yes _____ No _____

Are you currently taking prescribed medications? Yes _____ No _____

If yes, please list: _____

Are you currently taking Hormone replacements? Yes _____ No _____

If yes, list the name and duration: _____

Have you ever been diagnosed with Hyper-Parathyroidism? Yes _____ No _____

Have you ever experiences any broken bones? Yes _____ No _____

If yes, at what age(s): _____

Have you ever had hip surgery? Yes _____ No _____

If yes, at what age? _____

Have you ever had back surgery? Yes _____ No _____

If yes, at what age? _____

Have you ever had an organ transplant? Yes _____ No _____

If yes, what organ and when? _____

Are you post menopausal? Yes _____ No _____

If yes, at what age? _____

Signature

Date