Bone Density: Follow-Up Patient History Form

Today's Date:	**Name:**		**Date of Birth:**	**Gender:**
Address:		**Phone Number(s):**	**Email:**	

Who ordered this bone density test? ____

Shall we fax copies of your report to any other physician? ____

May we contact you for possible participation in research studies? **Yes** ❒ **No** ❒

What is the name of the osteoporosis medication you are taking, if any? ____

When did you start it? ____

If you have previously stopped osteoporosis medication, when did you stop it? ____

Since your LAST bone density, have any of the following occurred? Please answer "**Yes**" or "**No**".

Are you currently a cigarette smoker? **Yes**____ or **No**____

If yes, please explain: ____

Do you average more than 2 alcoholic drinks per day? **Yes**___ or **No**___

If yes, please explain: ____

Have you been diagnosed with rheumatoid arthritis or thyroid disease? **Yes**___ or **No**___

If yes, please explain: ____

Have you been started on steroids, such as prednisone? **Yes**___ or **No**___

If yes, please explain: ____

Have you had surgery, surgical implants, or hospitalizations? **Yes**___ or **No**___

If yes, please explain: ____

Have you had a fracture (broken bone)? **Yes**___ or **No**___

If yes, please explain: ____

Did your mother or father break a hip? **Yes**___ or **No**___

If yes, please explain: ____

Have you been diagnosed with cancer? **Yes**___ or **No**___

If yes, please explain: ____

Have you had digestive/malabsorptive problems? **Yes**___ or **No**___

If yes, please explain: ____

Have you had changes in your medication(s)? **Yes**___ or **No**___

If yes, please explain: ____

Technologist Notes:

____

Measured Weight: _______________ Measured Height____________ Revision 9/14/2022