New Mexico Clinical Research & Osteoporosis Center, Inc.

Bone Densitometry: Patient History Form

Name:		DOB:	Date:
Address:	Home Phone:	Cell Phone:	

Who ordered this bone density test? ______________________________

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

What is the reason for doing this bone density test? ______________________________

Have you had a bone density test before? Yes___ No ___ If yes, when and where? ______________________________

Ethnic Group:

☐Caucasian ☐Hispanic ☐Asian/Pacific Islander ☐African American ☐Native American ☐Other _________

Gender: ____________

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

Osteoporosis Risk Factor Assessment

Have you:	**YES**	**NO**
Lost more than 1.5 inches in height?	☐	☐
Broken bones since age 40?	☐	☐
Ever taken steroids, such as prednisone, for more than 3 months?	☐	☐
Been on chemotherapy?	☐	☐
Had stomach surgery such as gastrectomy or stapling (surgery for obesity)?	☐	☐
Had anorexia?	☐	☐
Had bulimia?	☐	☐
Had an organ transplant?	☐	☐

Do you:	**YES**	**NO**
Smoke cigarettes?	☐	☐
Now take prednisone?	☐	☐
Have diabetes?	☐	☐
Have kidney disease?	☐	☐
Nephrologist: ______________________		
Have rheumatoid arthritis?	☐	☐
Rheumatologist: ______________________		
Take anticonvulsant medication, like Dilantin, Phenobarb, or Tegretol?	☐	☐
Have any thyroid problems?	☐	☐
Hyper (overactive) ____ *Hypo (underactive)* _____		
Endocrinologist: ______________________		
Have any parathyroid problems?	☐	☐
Hyper (overactive) ____ *Hypo (underactive)* _____		
Endocrinologist: ______________________		
Have a high calcium level in your blood?	☐	☐
Have inflammatory bowel disease like Crohn's Disease, or ulcerative colitis?	☐	☐
Have malabsorption problems or celiac disease?	☐	☐
Have a paralyzed arm or leg?	☐	☐
Have on average 3 or more alcohol drinks per day?	☐	☐
Does your mother or father have osteoporosis?	☐	☐
Mother _____ *Father* ____		
Has your mother or father had a broken hip?	☐	☐
Mother ________ *Father* ________		
At what age? ______		

Gender Specific Risk Factors

For women only:	**YES**	**NO**
Are you currently having irregular periods?	☐	☐
Has there been an episode when your period stopped for a significant amount of time?	☐	☐
Have you ever had phlebitis or blood clots?	☐	☐
Have you had breast cancer?	☐	☐

If yes, date diagnosed ___________________

Right ___ *Left* ___

Chemo ____ *Radiation*____ *Surgery* ___

Have you ever taken Femara (letrozole), Arimidex (anastrazole), Aromasin (exemestane), or Tamoxifen?

If yes, for how long? ___________________

Are you still taking it? ☐ ☐

Have you had cancer of the…?

☐*Ovary (right__ or left __)* ☐*Uterus* ☐*Cervix* ☐*None*

Date diagnosed? _______________

Chemo ____ *Radiation* ____ *Surgery*____

At what age was your LAST period? ________

At what age did menopause begin? ________

How did menopause begin?

☐*Natural* ☐*Chemotherapy* ☐*Surgery*

If by surgery, was one ovary removed or both ovaries?

☐ *One ovary removed* ☐ *Both ovaries removed*

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Name:	DOB:	Date:

This box for men only:

	Unknown	YES	NO
Do you have erectile dysfunction		☐	☐
Do you have low testosterone?	☐	☐	☐
Have you had prostate cancer?		☐	☐

If yes, date diagnosed? ________________

Hormone Therapy ____ *Radiation* ____ *Surgery* _____

		YES	NO
Are you currently receiving hormone therapy for prostate cancer?		☐	☐

General Health Information:

What was your **height** at age 25? _________________

What was your **weight** at age 25? _________________

Have you ever broken or fractured a bone? ☐ Yes ☐No

Which bone?	Age	What happened?
☐right ☐left		
☐right ☐left		
☐right ☐left		
☐right ☐left		

Do you exercise regularly? ☐Yes ☐ No

Form of exercise	Frequency per week	Length of time per workout

Do you currently take, or have you ever taken the following medications?

		Are you on this now?	**Dose**	**Date Started**	**Date Stopped**	**Reason Stopped**
❒	Calcium					
❒	Calcium with Vitamin D					
❒	Multivitamin					
❒	Vitamin D					
❒	Estrogen ❒patch ❒pill ❒cream					
❒	Testosterone					
❒	Prednisone					
❒	Fosamax (alendronate)					
❒	Actonel, Atelvia (risedronate)					
❒	Evista (raloxifene)					
❒	Miacalcin, Fortical (calcitonin)					
❒	Forteo (teriparatide)					
❒	Boniva (ibandronate)					
❒	Reclast (zoledronic acid)					
❒	Prolia (denosumab)					
❒	Tymlos (abaloparatide)					
❒	Didronel (etidronate)					
❒	Evenity (romosozumab)					
❒	Strontium					

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Name:	DOB:	Date:

Please list all other medications you are currently taking. (Write none if none)

Are there any other details to any of your answers on this questionnaire you feel we should know?

____

____

____

STOP: DID YOU COMPLETE ALL 3 OF THE PAGES?

For Official Use

HT cc:

WT L R JC MG SE DXA

Notes