



PATIENT HISTORY FORM – BONE MINERAL DENSITY -- FEMALE

PATIENT NAME _____ Date of Birth: _____

Have you had a prior Bone Mineral Density scan? Yes ___ No ___ Year ___

Height: ___ feet ___ inches Weight: ___ lbs. Are you pregnant? Yes ___ No ___

Right handed? ___ Left Handed? ___ Have you had a hysterectomy? Yes ___ No ___ Partial ___

Menopause Status: Pre-menopausal ___ Menopausal Symptoms ___

Post-menopausal ___ Menopause Age: ___

Are you on hormone replacement therapy (HRT)? Yes ___ No ___ Patch ___

Have you been diagnosed with osteopenia? Yes ___ No ___ With osteoporosis? Yes ___ No ___

Do you have a family history of osteoporosis? Yes ___ No ___
If yes to family, who? _____ Age _____

Have you had any bone or spine surgeries? Yes ___ No ___
If yes, please describe _____

Have you had a nuclear exam using contrast medium in the **last 5 days**? Yes ___
Bone scan ___ Thyroid scan ___ Other _____

Medications Currently Used:

- ___ Fosamax
- ___ Actonel
- ___ Boniva
- ___ Evista (Raloxifene)
- ___ Fortero
- ___ Other Bone Meds

Have you ever been treated with:

- ___ Thyroid pills
- ___ Chemotherapy Treatment
- ___ Tamoxifen (Nolvadex)
- ___ Miacalcin (Calcitonin)
- ___ Sterioids (cortisone-like)
- ___ Other _____

Daily exercise Yes ___ No ___ on average how many times a week ___

Daily Vitamin D & Calcium Supplements ___ Multi-Vitamin ___ Other ___

Do you currently smoke? _____

Do you consume 1 or more alcoholic beverages daily? _____

Did your Mother or Father have hip fractures? _____

Have you ever been treated for insulin dependent diabetes? _____

Have you ever been treated for chronic liver disease or malabsorption? _____

Have you been diagnosed by a doctor with rheumatoid arthritis? _____

Ethnicity

Asian ___ Black ___ Hispanic ___ Caucasian ___

SIGNATURE _____ Today's Date: _____

Tech
Notes

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