



**PATIENT HISTORY FORM – BONE MINERAL DENSITY - MALE**

PATIENT NAME \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Have you had a prior DEXA?      Yes              No

Height \_\_\_\_\_      Weight \_\_\_\_\_ lbs

Are you right handed? \_\_\_\_\_      Left handed? \_\_\_\_\_

Have you been diagnosed with osteopenia?              Yes              No

Have you been diagnosed with osteoporosis?              Yes              No

Do you have a family history of osteoporosis?              Yes              No  
If yes to family, who? \_\_\_\_\_

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              No  
Bone scan \_\_\_\_\_      Thyroid scan \_\_\_\_\_      Other \_\_\_\_\_

Medications Currently Used:

- \_\_\_\_\_ Fosamax
- \_\_\_\_\_ Actonel
- \_\_\_\_\_ Boniva
- \_\_\_\_\_ Evista (Raloxifene)
- \_\_\_\_\_ None of the above

Have you ever been treated with:

- \_\_\_\_\_ Sterioids (cortisone-like)
- \_\_\_\_\_ Miacalcin (Calcitonin)
- \_\_\_\_\_ Thyroid Pills
- \_\_\_\_\_ Chemotherapy treatment
- \_\_\_\_\_ Other

Daily exercise    Yes \_\_\_\_    No \_\_\_\_    or 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 Farther 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

HGT

WGT

Notes

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