Atlantic Medical Imaging- Bone Density History

Name:_____ Today's Date: _____

Patient ID:_____ Sex: ❑F ❑M

Current Height: (in) _____ Date of Birth: _____

Weight: (lb) _____ Referring Physician: _____

Menopause Age: _____ Ethnicity: _____

Medications: _____

What symptoms are you having that led your doctor to order this exam: _____

ICD10 (translation – each code): _____

Encounter for today's exam: ❑Initial ❑Follow Up Level of Pain (1-10): _____

General History:

1. Have you had a previous hip or vertebral fracture?	❑Yes	❑No
2. Have you had any fractures during your adult life which did not result from significant trauma (e.g., auto accident)?	❑Yes	❑No
3. Did either of your parents ever have a hip fracture?	❑Yes	❑No
4. Do you smoke?	❑Yes	❑No
5. Have you ever taken steroids?	❑Yes	❑No
6. Do you have rheumatoid arthritis?	❑Yes	❑No
7. Do you have secondary osteoporosis?	❑Yes	❑No
8. Do you drink 3 or more alcoholic drinks per day?	❑Yes	❑No
9. Are you being treated for osteoporosis?	❑Yes	❑No

10. Have you ever taken any of the following medications:

❑Actonel (i.e. risedronate) ❑Boniva (i.e. ibandronate)
❑Evista (i.e. raloxifene) ❑Forteo (i.e. parathyroid hormone)
❑Fosamax (i.e. alendronate) ❑HRT (i.e. estrogen/hormone therapy)
❑Miacalcin (i.e. calcitonin) ❑Protelos (i.e. strontium ranelate)
❑Reclast (i.e. zoledronate) ❑Prolia (i.e. denosumab)
❑Vitamin D ❑Calcium
❑Other (Please specify): _____

11. Do you have any of the following medical conditions:

❑Anorexia or Bulimia ❑Any Seizure Disorders ❑Asthma or Emphysema ❑Cancer
❑End Stage Renal Disease ❑Inflammatory Bowel Disease ❑Hyperparathyroidism ❑Hysterectomy
❑Hypertension ❑Diabetic – Any complications?_____
❑Other (Please specify): _____

12. What was your maximum height (inches)? _____

13. Do you perform weight bearing exercise regularly?	❑Yes	❑No
14. Do you regularly consume dairy products?	❑Yes	❑No
15. Do you drink caffeinated beverages?	❑Yes	❑No

For Women Only:

16. At what age did your period start? _____

17. Are you pregnant?	❑Yes	❑No

If yes, what trimester? ❑1st ❑2nd ❑3rd

18. How many full term pregnancies have you had? _____

19. Have you ever missed your period for more than 6 months in a row (not including pregnancy or menopause)?	❑Yes	❑No
20. Are you premenopausal?	❑Yes	❑No

Signature: _____