

Bone Density Examination Information

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: _____