HerCare at Amarillo Diagnostic Clinic, P.A.

BONE DENSITOMETRY
PATIENT HISTORY

Please complete the following questions to the best of your ability. If you are unclear what to answer, leave the space blank and we will help with the answer when you are seen at this facility. All answers will be kept in strict confidence and treated as information in your medical record.

Your Name:_____ Date:_____

Date of Birth:_____ Pt #:_____

Previous Bone Density Location:_____

1. Sex: □ Female □ Male
2. Race: □ African-American □ Asian □ Hispanic □ White □ Other
3. If you wish a copy of your bone density report to go to an additional doctor, please give us

   his/her name:_____

   and address:_____

4. The following medicines and supplements may be used to treat osteoporosis. Please place a check beside each one you are taking.

   CALCIUM SUPPLEMENTS

   □ Taking calcium but dose unknown □ 1000-1499 mg per day
   □ 500-000 mg calcium per day □ 1500 mg or more calcium per day

   VITAMIN D:_____ I.U. per day

   HORMONES

   □ estrogen (Premarin, Ogen, Estrace, Estraderm or Vivelle or Climara patch, etc.)
   □ estrogen & progestin (prempro, Premphase, Premarin & Provera, CombiPatch, estrogen and Prometrium, Femhrt, Ortho-Prefest, etc.)
   □ estrogen & testosterone (Estratest)
   □ vaginal estrogen

Other medications that affect bone health:

□ Alendronate (Fosamax) Duration of use_____

□ Risedronate (Actonel) Duration of use_____

□ Calcitonin (Calcinar, Miacalcin) Duration of use_____

□ Parathyroid hormone (Forteo) Duration of use_____

□ Letrozole (Femara) Duration of use_____

□ Ibandronate (Boniva) Duration of use_____

□ Zoledronic acid (Reclast) Duration of use_____

□ Raloxifene (Evista) Duration of use_____

□ Tamoxifen (Nolvadex) Duration of use_____

□ Anastrozole (Arimidex) Duration of use_____

□ Denosumeb (Prolia) Duration of use_____

If discontinued, why_____

5. Have you ever had cancer? □ YES □ NO
   If yes, what type and when?_____
6. Have you ever fractured any bones? □ YES □ NO
   If yes, which bone?_____
   At what age?_____
   How?_____
7. Have any of your relatives suffered a broken hip or shoulder, lost height or had osteoporosis when past the age of 45? □ YES □ NO
   Which relative?_____
8. Have you lost any of your height in the last few years? □ YES □ NO
   What is your tallest lifetime height measured in stocking feet?_____
9. Do you exercise less than four times per week? □ YES □ NO
10. Do you drink more than two alcohol drinks per day? □ YES □ NO
11. Have you smoked in the past? □ YES □ NO
12. Do you smoke currently? □ YES □ NO
    How much do you smoke?_____
13. Do you drink more than five or more cups of coffee or soda (containing caffeine) each day? □ YES □ NO
14. How many dairy servings per day do you eat/drink?_____
15. Do you have partial or complete paralysis? □ YES □ NO
16. Do you have hyperthyroidism (overactive thyroid)? □ YES □ NO
17. Do you have kidney failure (on dialysis or may need it in the future)? □ YES □ NO
18. Do you have rheumatoid arthritis? □ YES □ NO
19. Has part of your stomach been removed (gastrectomy)? □ YES □ NO

20. Have you had a surgery for weight loss? □ YES □ NO
    Type: □ gastric bypass □ banding □ stapling □ other
21. Do you have a serious disease of the intestines such as Crohn's disease, Ulcerative Colitis, or Celiac disease? □ YES □ NO
22. Do you have hyperparathyroidism (over-active parathyroid gland)? □ YES □ NO
23. Are you now on a form of cortisone (such as prednisone) or have you taken it for more than three months in the past? □ YES □ NO
    What is the name?_____
    What is the dose?_____
    What is it for?_____
    Is it injection, nasal inhalant, cream or pill?_____
    How long have you been on it?_____
24. Have you ever had a venous thrombolic event such as:
    Stroke □ YES □ NO
    Blood clot (thrombosis or thrombophlebitis) □ YES □ NO
    Pulmonary embolism □ YES □ NO
    Retinal vein thrombosis □ YES □ NO
25. Are you or have you ever taken an anticoagulation drug (i.e., Coumadin, Heparin, or Lovenox)? □ YES □ NO
    If so, when and for how long?_____
26. Have you had any testing or procedure within the last 7 days using contrast dye such as for IVP, barium enema or upper GI x-rays? □ YES □ NO
27. Have you had a nuclear medicine scan in the last 7 days? □ YES □ NO
    If yes, what type?_____

FEMALES ONLY:

28. Are you pregnant or do you suspect pregnancy? □ YES □ NO
29. Have you had your ovaries removed? □ YES □ NO
    If so, when was this done?_____