

ULTRASOUND ASSOCIATES

Women's Imaging Center

PATIENT BONE DENSITOMETRY INFORMATION

Date: _____

Name: _____ Date of Birth: _____

Height _____ Weight _____ Ethnicity _____

1. Have you been diagnosed with osteoporosis? YES ___ NO ___
If yes, are you taking medication for osteoporosis? YES ___ NO ___ TYPE _____

2. Do you have family history of osteoporosis? YES ___ NO ___

3. Do you currently use tobacco products? YES ___ NO ___

4. Do you have a history of any of the following?
Amenorrhea (absent menses) YES ___ NO ___
Anorexia or Bulimia YES ___ NO ___
Hyperthyroidism YES ___ NO ___
Hypothyroidism YES ___ NO ___
Hyperparathyroidism YES ___ NO ___
Renal Failure YES ___ NO ___
Gastric or intestinal resection YES ___ NO ___
Oophorectomy (removal of ovaries) YES ___ NO ___
Organ transplant YES ___ NO ___
Cancer YES ___ NO ___

If yes, site? _____

In remission more than 5 years? YES ___ NO ___

Arthritis YES ___ NO ___

If yes, where? _____ TYPE: _____

5. Are you postmenopausal? YES ___ NO ___

If yes, when did you start menopause? _____

Are you taking hormone replacement therapy? YES ___ NO ___

If yes, what type? _____

6. Have you had any of the following?
Hip fracture, surgery or hip replacement YES ___ NO ___ RT ___ LT ___

Spine fracture YES ___ NO ___

If yes, circle site Cervical Thoracic Lumbar

Stress Fractures YES ___ NO ___

Other Fractures (adult age) YES ___ NO ___

If yes, give location of fracture(s) _____

Loss of height of 1 or more inches YES ___ NO ___

7. Are you taking any of the following medications?
Thyroid Medications YES ___ NO ___ TYPE _____

Calcium Supplements YES ___ NO ___

Anticonvulsant Medication YES ___ NO ___

Steroids: YES ___ NO ___

If yes, circle type: Oral Inhalational

If yes, for how long? _____

Heparin/Coumadin YES ___ NO ___