Bone Density Assessment

for Females

Appointment Date: ____/____/_____ Time: _____ : _____ (AM/PM) Date of Birth: ____/____/_____

Patient Name: _____

Account Number: _____ Weight: _____ Height: _____

Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

Reason for Test: _____

Referring Physician: _____

Yes	No	
☐	☐	Have you had a previous bone density exam?
☐	☐	Have you had hip surgery?
☐	☐	Have you had lumbar spine surgery?
☐	☐	Since the age of 20, have you broken a bone? If yes, what have you broken? _____ _____
☐	☐	Do you have a family history of osteoporosis? What relation to you? _____ _____
☐	☐	Has anyone in your family had a hip fracture as an older adult?
☐	☐	Have you had a hysterectomy? If yes, when? _____
☐	☐	Do your ovaries remain? Approximately what age did you begin menopause? _____
☐	☐	Do you smoke cigarettes?
☐	☐	Have you smoked in the past? When did you quit? _____
☐	☐	Do you drink alcohol? If yes, how many drinks daily? _____

Medications (check all that apply)

- ☐ Calcium/Vitamin D _____mg ____times/day
- ☐ Multi-vitamin
- ☐ Female hormones
- ☐ Fosamax
- ☐ Actonel
- ☐ Boniva
- ☐ Evista
- ☐ Miacalcin nose spray
- ☐ Reclast infusion
- ☐ Prednisone
- ☐ Seizure medication
- ☐ Thyroid medication
- ☐ Inhaled steroids

Additional medical history (check all that apply)

- ☐ Breast cancer
- ☐ Uterine cancer
- ☐ Rheumatoid arthritis
- ☐ Thyroid disease
- ☐ Kidney stones
- ☐ Dialysis

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