



Patient Focused • Quality Oriented • Physician Driven

Regional Arthritis & Osteoporosis Center
Specializing In Bone Density Testing and Osteoporosis

Name _____ Date of Birth _____ Age _____

Please answer the following questions:

Have you had a bone density test before? Yes ___ No ___ When _____ Where _____

Sex: Male ___ Female ___ Current weight: _____ Height _____

Fracture history: _____

(Please indicate fracture site and your age at time of fracture)

Ordering Physicians Name: _____

Medication : Please circle if you are taking any of the following:

Fosamax	Miacalcin	Calcium Supplement	Estrogen
Actonel	Evista	Vitamin D	Steroids (prednisone)
Forteo	Thiazide (water pill)	Thyroid Supplement	Alendronate
Reclast	Boniva	Boniva IV	If yes how long? _____

Other Medications _____

Have you had any of the following surgeries? Hip ___ Back ___ Thyroid _____

Medical History: Please circle if you have any of the following conditions:

Hyperthyroid Epilepsy Diabetic Cushings Cancer Asthma Scoliosis Hyperparathyroid
Rheumatoid Arthritis

Other medical conditions _____

In the past 2 weeks have you had radiology testing involving dye or contrast materials? Yes ___ No ___

Have you taken calcium today? Yes ___ No ___

Female Patients:

Are you pregnant? Yes ___ No ___ Past Menopause: Yes ___ No ___ Age _____

Hysterectomy Yes ___ No ___ If yes, were both ovaries removed? Yes ___ No ___

At what age did you have the hysterectomy ? _____

Signature _____ Date _____