BONE MASS DENSITY SCREENING FORM

**Patient Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_

**Referring Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex:**🞎M 🞎 F

**Ethnicity**: 🞎 Caucasian 🞎 Black 🞎 Hispanic🞎 Asian **Weight (lb)**\_\_\_\_\_\_\_\_\_\_**Height (in)**\_\_\_\_\_\_\_\_\_\_\_\_

**🞎 YES 🞎 NO** Have you had any previous Bone Density Testsperformed? If yes, when and where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**🞎 YES 🞎 NO** Have you had a previous hip or vertebral fracture?

**🞎 YES 🞎 NO** Have you had any fractures which did not result from significant trauma (e.g. auto accident)?

**🞎 YES 🞎 NO** Did either of your parents ever have a hip fracture?

**🞎 YES 🞎 NO** Do you smoke?

**🞎 YES 🞎 NO** Have you ever taken glucocorticoids?

**🞎 YES 🞎 NO** Do you have rheumatoid arthritis?

**🞎 YES 🞎 NO** Do you have secondary osteoporosis?

**🞎 YES 🞎 NO** Do you drink 3 or more alcoholic drinks per day?

**🞎 YES 🞎 NO** Are you being treated for osteoporosis?

**🞎 YES 🞎 NO** Do you perform weight bearing exercise regularly?

**🞎 YES 🞎 NO** Have you ever taken any of the following medications? (check all that apply)🞎 Actonel 🞎 Boniva 🞎Evista🞎Forteo🞎 Fosamax 🞎 HRT (hormone replacement therapy) 🞎Miacalcin🞎Protelos🞎Reclast🞎 Prolia🞎 Vitamin D 🞎 Calcium 🞎 Steroids (longer than 3 months) 🞎 Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**🞎 YES 🞎 NO** Do you have or had any of the following medical conditions? 🞎 Anorexia/Bulimia 🞎 Seizure disorder 🞎 Asthma 🞎 Emphysema 🞎 Cancer (type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) 🞎 End Stage Renal Disease 🞎 Inflammatory Bowel Disease 🞎 Hyperparathyroidism 🞎 Hysterectomy

**FEMALES ONLY**:

**🞎 YES 🞎 NO**Are you:🞎premenopausal🞎menopausal🞎post menopausal

If yes, at what age did it start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

**Technologist Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_