Arthritis & Osteoporosis Center, P.C.
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BONE DENSITOMETRY PATIENT HISTORY

All Answers will be kept in strict confidence and treated as information in your medical record.

Name:_____ Phone:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Sex: Male____ Female_____ Age:_____ Date of Birth:_____

Ordering Physician: _____

1. Are you currently taking any of the following: (please circle)

Fosamax (Alendronate)	Actonel (Risidronate)
Didronel (Etidornate)	Boniva (Ibandronate Sodium)
Premarin, Ogen, Estraderm patch, etc. (Estrogen)	Reclast Infusion
Calcium Supplements - Dose _____	Forteo
	Vitamin D

2. Do you exercise? Weekly_____ Monthly_____ Never_____
3. Do you drink more than 2 alcoholic drinks per day? YES NO
4. Do you smoke? YES NO
5. Do you drink 5 or more caffeine (coffee, soda, tea) drinks per day? YES NO
6. Do you eat more than 3 dairy products per day? YES NO
7. Are you taking cortisone (i.e. prednisone) YES NO
8. Have you taken cortisone in the past for more than 2 months? YES NO
9. Do you have a serious intestinal disease such as Crohn's colitis, or sprue? YES NO
10. Have you fractured any bones in your adult life? YES NO
11. Does anyone in your family have Osteoporosis? YES NO
12. FEMALES ONLY: At what age did your period start? _____ Stop_____
13. What is the tallest you have been in your lifetime? _____
14. List all medications: _____

_____

15. May we have permission to contact you directly if an appropriate research study becomes available?
YES - Phone Number: _____ NO _____

Signature: _____ Date:_____

For Office Only
Height:_____
Weight: _____