



BONE MINERAL DENSITY PATIENT INFORMATION

Name: _____

Date: _____ Date of Birth: _____

Age: _____ Medical Record Number: _____

Referring Physician: _____ Sex: F M

Ethnicity: This information is required for interpretation only, as Bone Density values may vary in different ethnic group. Please check the appropriate answer:

African-American White/Caucasian Hispanic Asian Other _____

Please check the appropriate answers:

1. Do you have Osteoporosis? Yes No

2. Do you have a family history of Osteoporosis? Yes No

3. Have you had a Hysterectomy (surgical removal of uterus)? Yes No

a. If so, what age? _____

4. Have you gone through menopause? Yes No

a. If yes, indicate age of onset: _____

5. Do you experience post-menopausal bleeding? Yes No

6. Absence of menstruation (i.e loss of period other than pregnancy or menopause)? Yes No

7. Do you take estrogen? Yes No

8. Do you take any other therapy for raising Bone Density? Yes No

a. If yes to 7 or 8 indicate duration _____

9. Have you ever fractured or had surgery to your hip, spine or wrist? Yes No

10. Have you ever been on oral steroids (tablets) for longer than 3 month? Yes No

11. HEIGHT _____ WEIGHT _____